



CUMBERLAND COUNTY COUNCIL

THE HEALTH
OF
CUMBERLAND
1970

REPORT OF THE
COUNTY MEDICAL OFFICER



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COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON

THE HEALTH OF THE COUNTY

FOR THE YEAR 1970

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,

M.R.C.S., L.R.C.P., D.P.H.,

County Medical Officer.

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P R E F A C E

To the Chairman and Members of the County Council,

The theme for the continuing advance of community medicine in Cumberland in 1970 was the ongoing need for comprehensive health planning. There was need also for greater definition of the position of the Medical Officer of Health, or Community Physician, in the development of a blue print for comprehensive health care.

However, the Chief Medical Officer of Health to the Department of Health and Social Security has already written:—

“It will be lamentable to the future of social medicine and gravely limiting to the development of our services if the present generation of administrative doctors does not seize the opportunity now opening before it of providing in every district, the community physician who will promote the organisation of medical care in all its curative and preventive aspects and in the larger areas the essentially medical part of better administration. This needs partnership with, not control of, a new administration of social case-work”.

The development of services in the year included the implementation of a scheme using automatic data processing for call up procedures to bring all infants to appropriate group practice premises throughout the whole of the county for vaccination and immunisation. I am confident that this scheme will prove a great success. The year also saw an advance in the use of hospital premises for local authority services — a chiropody clinic in Maryport hospital and agreement to school dental services being sited in the Keswick Cottage Hospital — both particularly happy moves at a time when statutory integration is imminent. The dental service itself underwent a change in that for the first time a dental auxiliary was employed in the service.

The orientation of the ambulance personnel towards a more professional view of their work following upon the publication of the McCarthy Report was another important advance, as is the

realisation of how important to a rural community is the properly trained ambulance driver attendant.

Another important development following the receipt of the Mayston Report was on-going inservice management training for top, middle and first line nursing staff. I consider this Report signposts the way to the integration of the nursing service both in and out of hospital.

There is an overall feeling of frustration and of marking time amongst the Health Department staff associated with the proposed changes in structure of local government and the National Health Service. There is also some feeling of frustration about the lack of progress in the provision of health centres, for it must be remembered that group practice premises are not always suitable for the easy and convenient working of such important members of the family health team, as health visitors, district nurses, and domiciliary midwives.

The report itself indicates that vital statistics continue to show steady overall improvement, the main community disease being connected with degenerative processes associated with ageing. There is a low birth rate, a steady death rate and the total population is steady, if not declining. That some 10,030 children have been born in this county since the last mother died in childbirth is a truly remarkable record.

The still expanding work of all the voluntary services in Cumberland during the year, in what is conveniently termed community care, has been carried out wonderfully well and with a confident and quiet efficiency. All statutory schemes now have a planned voluntary component, and the service for the patient and his family is so much better for this. We are all greatly indebted to the voluntary societies for this excellent work.

The small Department of Community Health at the West Cumberland Hospital has been proven without doubt to be a suitable place for the Medical Officer of Health to use as a centre from which he can meet and get first-hand views from his colleagues in hospital clinical medicine and thus gain further

insight into total community health needs and the methods of providing for them within contemporary resources.

I make no apologies for returning to the health problem of cigarette smoking. During the last twenty years it has been clearly shown by many clinical and epidemiological studies, supported by detailed laboratory investigations, that cigarette smoking impairs health to such a serious degree that means for its control must be developed. It has been shown to play a major part in the development of many diseases, the most important of which are ischaemic heart disease, lung cancer, chronic bronchitis and emphysema, and to cause widespread and distressing disability from chest and heart diseases. It is not practicable to impose regulations on an unwilling population in an attempt to bring about a reduction in cigarette smoking, but as the mortality is lower in cigarette smokers who have stopped smoking than in those who have continued to smoke, it is essential that some steps are taken to promote the discontinuance or at least reduction of the habit. More importantly, something must be done to discourage young people from starting to smoke and in this I believe that the schools have a major part to play. How they can most effectively play this part is being discussed with the Director of Education.

Thanks are due to all in the integrating health service in this area and especially to all the staff of the County Health Department, and indeed to all other Departments of the County Council with its wide ranging educational and social responsibilities.

I have the honour to be, Sir,

Your obedient Servant,

A handwritten signature in dark ink, reading "John Leiper". The signature is written in a cursive style with a large initial 'J' and a long, sweeping underline.

County Medical Officer of Health.

County Health Department,
11, Portland Square,
Carlisle. CA1 1QB.

STAFF

County Medical Officer and County Welfare Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P.,
D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Area Medical Officers—

C. A. Bentley, B.A., M.R.C.S., L.R.C.P., D.P.H., Northern Area Medical Officer; Medical Officer of Health to the Penrith Urban District Council and the Border, Wigton and Penrith Rural District Councils.

A. Hargreaves, M.B., Ch.B., D.P.H., Western Area Medical Officer; Medical Officer of Health to Workington Borough and Port, Cockermouth Rural District and Cockermouth, Keswick and Maryport Urban District Councils.

H. M. Marks, B.A., M.B., B.Ch., D.P.H., Southern Area Medical Officer; Medical Officer of Health to Whitehaven Borough and to the Ennerdale and Millom Rural District Councils.

Deputy Area Medical Officers—

J. Connolly, M.D., D.P.H., Deputy Northern Area Medical Officer and Deputy Medical Officer of Health to the Penrith Urban District Council and the Border, Wigton and Penrith Rural District Councils.

L. H. Thacker, M.B., B.S., D.A., D.P.H., Deputy Southern Area Medical Officer and Deputy Medical Officer of Health to Whitehaven Borough Council and to the Ennerdale and Millom Rural District Councils.

Medical Officers in Senior Posts—

J. E. Ainsworth, M.B., Ch.B.

J. E. M. Garland, M.B., Ch.B., D.P.H.

M. P. McMillan, M.B., Ch.B.

Medical Officers in Department—

J. R. Hassan, M.B., Ch.B., D.Obst., R.C.O.G. (Also Medical Officer of Health, Alston with Garrigill Rural District, and General Practitioner).

K. R. Walker, M.B., Ch.B.

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Western Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

D. Allan, B.D.S.

K. M. Burnett, B.D.S.

J. Colvin, L.D.S.R.F.P.S.

Miss A. Corkhill, B.D.S.

A. B. Gibson, B.D.S.

F. H. Jacobs, L.D.S.

A. R. Peck, L.D.S.

A. M. Scott, L.D.S.

Welfare Services Officer—

N. Froggatt

Deputy Welfare Services Officer—

I. Duthie, C.S.W., D.P.A.

Social Welfare Officers—

Northern Area

I. H. Moffet, C.S.W., Senior Welfare Officer

M. Steels

M. H. Payne

G. A. H. Miller

Miss J. E. Campling

Western Area

Miss E. F. Hall, Senior Welfare Officer
A. Davidson, R.M.N., S.R.N., C.S.W.
T. Hetherington, C.S.W.
A. Irving
Miss L. L. Morris
T. Postlethwaite
B. Reeves

Southern Area

J. M. Ruddick, C.S.W., Senior Welfare Officer
R. Daley
T. Evans, R.M.N.
B. Hickie, R.M.N.
Miss R. Youngman, S.R.N.

Matrons of Residential Accommodation—

W. L. Anderson, S.R.N., Q.N., Alneburgh House, Maryport.
Mrs. M. Beresford, Ravensfield, Keswick.
Mrs. M. Campbell, Castle Mount, Egremont.
Mrs. D. J. Crew, S.E.N., Eskdale House, Longtown.
Miss M. J. Dewhurst, Park Lodge, Aspatria.
Mrs. P. B. Grahamslaw, S.R.N., Inglewood, Wigton.
Mrs. A. L. Hill, S.R.N., Greengarth, Penrith.
Miss M. Ivison, Grange Bank, Wigton.
Miss M. Johnson, Richmond Park, Workington.
Mrs. M. M. Maclagen, Moot Lodge, Brampton.
Mrs. H. J. Milnes, Derwent Lodge, Papcastle.
Mrs. H. I. Peart, Grisedale Croft, Alston.
Miss A. G. Ross, S.R.N., Parkside, Maryport.
Mrs. V. M. Underwood, Lapstone House, Millom.
Mrs. B. Wadsworth, R.N.M.S., Fairview Hostel, Bransty,
Whitehaven.
Mrs. R. Wilson, S.R.N., Brackenthwaite, Whitehaven.
Miss A. D. Wright, Garlieston, Whitehaven.
Miss V. Woodman, S.R.N., The Towers, Skinburness.

Home Teachers for the Blind—

Miss J. Burgess
Miss L. D. Fraser
Mrs. G. Mossop
Miss M. Shuttleworth

Training Centre Supervisors—

A. D. Berry, Dip.T.C.T.M.H., Manager, Adult Training Centre, Distington.
Mrs. H. Bowie, Junior Training Centre, Whitehaven.
Miss G. L. Lister, Dip.T.C.T.N.H., S.E.N., Junior Training Centre, Wigton.

Consultant Psychiatrist (Part-time) seconded from Newcastle Upon Tyne Regional Hospital Board—

T. R. Burgess, M.R.C.S., L.R.C.P., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Chief Nursing Officer—

Miss K. J. Hayes, S.R.N., S.C.M., D.N.Cert., H.V. Cert.,
N.Admin. Cert. (P.H.)

Deputy Chief Nursing Officer—

Miss J. Byatt, S.R.N., S.C.M., M.T.D., Q.N., H.V.

Area Nursing Officers—

Miss J. M. Crossfield, S.R.N., Q.N., H.V. Cert., N. Admin. Cert. (P.H.), Western Area.
Miss J. Reid, S.R.N., S.C.M., Q.N., H.V. Cert., Southern Area.
Mrs. J. M. Roberts, S.R.N., S.C.M., H.V. Cert., Q.N., Northern Area.

Chiropodists—

G. H. Thomas, M.Ch.S., S.R.Ch.
W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N.
Mrs. D. E. Smart, M.Ch.S., S.R.Ch.

Chiropodists (Cont'd)

Mrs. G. Garrett, M.Ch.S., S.R.Ch.
Mrs. J. Glaister, M.Ch.S., S.R.Ch.
Miss R. H. Cunliffe, M.Ch.S., S.R.Ch.
F. J. McCourt, M.Ch.S., S.R.Ch.

Orthoptists—

Mrs. J. A. M. Payne, D.B.O. (Part-time)
Mrs. J. Scott, D.B.O. (Part-time).

Physiotherapists—

Mrs. P. P. Bratt, M.C.S.P. (Part-time)
Miss M. Sivewright, M.C.S.P. (Part-time)

Screening Assistants—

Mrs. J. Laidlaw
Miss S. Easterbrook
Miss D. Kidd

Senior Speech Therapist—

Mrs. E. M. Blacklock, L.C.S.T.

Speech Therapists—

Mrs. J. Lahiff, B.Sc. (Speech)
Mrs. S. Latimer, L.C.S.T. (Part-time)
Miss E. B. Moon, L.C.S.T. (Part-time)
Mrs. M. E. Ogram, L.C.S.T. (Part-time)

Occupational Therapist—

Mrs. A. Lock, M.A.O.T.

County Ambulance Officer—

M. F. Smith, F.I.A.O.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

NORTHERN AREA FAMILY HEALTH CARE TEAMS DECEMBER 1970

General Practitioners

Dr. J. R. Hassan
Dr. A. M. Brown
Alston
Dr. A. K. Rankin
Dr. A. M. Rankin
Dr. A. C. Beeby
Aspatiria
Dr. H. P. Nelson
Dr. W. J. Lush
Dr. R. E. D. Nelson
Dr. J. C. Burn
Dr. I. J. Clark
Brampton
Dr. M. I. Cox
Dr. A. G. MacKenzie
Caldbeck
Dr. H. J. Bradley
Dr. D. Dickenson
Dr. G. McInroy
Dalston
Dr. N. W. Cameron
Hesket
Dr. N. C. F. Milne
Kirkoswald
Dr. D. A. McDonald
Dr. R. A. Maxwell
Kirkbride
Dr. R. A. Forrester
Longtown

Home Nurses

Mrs. E. M. Walton
Mrs. P. White (Relief)
Mrs. A. Davidson Aux.)
Miss S. West
Mrs. J. Dickinson (Relief)
Mrs. J. Eilbeck (Relief)

Mrs. M. Dobson
Miss M. Lowes
Mrs. F. Gaskin (Relief)
Mrs. K. M. Bell (Relief)
Mrs. T. Wight (Relief)
Mrs. P. Alexander (Aux.)
Miss E. Henderson
Mrs. R. A. Strickland (Relief)

Mrs. M. E. Wilde
Miss K. Winter
Mrs. M. Faulder (Relief)

Mrs. J. R. N. Pickering
Mrs. G. Dye (Relief)
Mrs. J. R. N. Pickering
Mrs. G. Dye (Relief)
Miss A. A. Cockton
Mrs. M. Bendle (Relief)

Miss V. Dodgson
Mrs. E. Little (Relief)

Midwives

Mrs. E. M. Walton

Miss S. West
Miss G. Jobson (Relief)

Mrs. M. Dobson
Miss M. Lowes
Mrs. F. M. Hurst (Relief)

Miss E. Henderson
Miss K. Winter (Relief)

Mrs. M. E. Wilde
Miss K. Winter

Mrs. J. R. N. Pickering
Mrs. J. R. N. Pickering
Miss A. A. Cockton
Mrs. D. Lancaster (Relief)

Miss V. Dodgson
Mrs. F. M. Hurst (Relief)

Health Visitors

Mrs. A. Gallacher

Miss C. M. Bannan
(Group Adviser)

Miss B. Knibbs
(Group Adviser)
Mrs. M. Dobson
Mrs. A. Gallacher
Mrs. E. Woolley

Miss E. Henderson
Miss P. B. Simpson (Relief)

Miss P. B. Simpson
Miss E. Henderson (Relief)

Mrs. D. Edmondson
Mrs. M. McCredie (Relief)
Mrs. M. McCredie
Mrs. D. Edmondson (Relief)
Mrs. D. Lancaster
(Group Adviser)

Miss M. Butler
(Group Adviser)
Mrs. B. Buchanan
(H.V. Assist.)

General Practitioners

Dr. G. M. Ingall
Longtown
Dr. H. C. Barr
Dr. I. M. Johnstone
Dr. G. F. Lewis
Dr. R. W. Corner
Penrith
Dr. G. H. Kilgour
Dr. C. H. Thomson
Penrith
Dr. K. Todd
Dr. J. B. Scott
Dr. I. O. Miller
Penrith
Dr. H. Hutton
Dr. R. M. Yule
Silloth
Dr. T. M. Dolan
Dr. G. A. H. Jones
Dr. N. Gray
Wigton

General Practitioners Practising Outside the Administrative County

Dr. K. Gillow
Dr. T. Mooney
Dr. T. Gardner
Dr. G. Raitt
Dr. J. Haworth
Dr. A. Frizell
Dr. A. Backman
Carlisle

Home Nurses

Mrs. F. M. Hurst
Mrs. E. J. Ralph
Mrs. M. Judson
Mrs. F. M. Hurst (Relief)
Mrs. V. M. Lamb
Mrs. J. Woodall
Mrs. S. A. Barnes
Mrs. E. Plant
Mrs. M. M. Barnard (Relief)
Mrs. E. Woodhall (Aux.)
Miss G. Jobson
Mrs. N. Reay
Mrs. D. Lancaster
Mrs. M. Hope
Mrs. M. Jones (Relief)
Mrs. M. Thom (Relief)
Mrs. E. M. Stafford
(Surgery Nurse)

Midwives

Mrs. V. M. Lamb
Mrs. S. A. Barnes (Relief)
Mrs. V. M. Lamb
Mrs. S. A. Barnes (Relief)
Mrs. S. A. Barnes
Mrs. V. M. Lamb (Relief)
Miss G. Jobson
Mrs. D. Lancaster
Miss A. A. Cockton (Relief)

Health Visitors

Miss K. Rigby
Miss D. Roulstone
Mrs. I. Kelly (Group Adviser)
Miss C. M. Bannan (Relief)
Mrs. D. Lancaster (Relief)
Mrs. M. Hedworth
Miss E. A. Lockhart

General Practitioners		Home Nurses	Midwives	Health Visitors
Dr. G. Jolly		Mrs. J. Branthwaite		Miss E. A. Lockhart
Dr. W. C. Menzies		Mrs. F. Yeomans (Relief)		
Dr. W. P. Honeyman				
Dr. N. C. Frame				
Dr. J. Kidd				
Carlisle				
Dr. E. M. Simpson		Miss A. A. Cockton	Miss A. A. Cockton	Miss E. A. Lockhart
Dr. I. L. Roy		Mrs. M. Bendle (Relief)		
Dr. B. Spencer				
Dr. W. G. H. Allan				
Carlisle				
All other Carlisle City Doctors				
		Mrs. J. Branthwaite		Miss E. A. Lockhart
		Mrs. F. Yeomans (Relief)		Miss D. Roulstone
		Mrs. V. M. Lamb	Mrs. V. M. Lamb	Miss D. Roulstone
Dr. D. M. C. Ainscow				
Temple Sowerby				
Dr. P. Delap		Mrs. J. Woodhall	Mrs. V. M. Lamb	Mrs. M. J. Mathews
Appleby				
Dr. J. D. Ogilvie		Mrs. M. J. Mathews	Mrs. M. J. Mathews	
Glenridding		Mrs. D. Scoon (Relief)		

SOUTHERN AREA FAMILY HEALTH CARE TEAMS DECEMBER 1970

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. Sharp	Miss J. Hardie	Miss J. Hardie	Miss J. Hardie
Dr. G. W. S. Burgess Distinguon	Mrs. M. Donnan		
Dr. W. G. McKay	Mrs. S. Hunter (Relief)		Mrs. P. Fitzgerald
Dr. C. Donald	Miss H. Spencer	Miss M. Proctor	Miss E. Miller (Geriatric Visitor)
Dr. H. Johnston	Miss M. Proctor		
Dr. N. McLeod			
Egremont & Cleator Moor			
Dr. W. T. Hunter	Mrs. A. Gell	Mrs. V. Wrightson	Miss M. Gibson
Dr. J. Veitch	Mrs. V. Wrightson		Miss R. Sheppard
Dr. D. Earnshaw	Mrs. M. Toole		Mrs. A. Donald
Dr. J. W. Strain	Mrs. A. Rae		
Dr. E. Braithwaite	Mrs. D. Adair (Relief)		
Egremont & Cleator Moor			
Dr. A. S. Smith	Mrs. F. Corkhill	Mrs. V. Wrightson	Miss A. Parkinson
Dr. L. Henry	Mrs. M. Weighman (Relief)		
Egremont & Cleator Moor			
Dr. J. Loudon	Miss D. James	Miss D. James	Miss D. James (Group Adviser)
Dr. J. W. Jago	Mrs. E. Brannan	Mrs. M. Marshall	Mrs. M. Marshall
Dr. J. M. Kirk Seascale	Mrs. M. Marshall		Mrs. M. Cutler
	Mrs. P. Heggie (Relief)		
	Mrs. E. Gallantry (Surgery Nurse)		
	Mrs. A. Brightman (Relief Surgery Nurse)		
Dr. A. M. Smith Seascale	Mrs. J. Capp	Mrs. M. Marshall	Mrs. M. Marshall
	Mrs. J. Wooley (Relief)		

General Practitioners		Home Nurses	Midwives	Health Visitors
Dr. A. E. Jackson		Miss I. Wilson	Miss I. Wilson	Miss M. Robinson
Dr. M. J. Leverton		Mrs. I. Booth	Mrs. I. Booth	Mrs. M. Moorhouse
Dr. A. J. Todd		Mrs. M. Wilson		
Dr. I. C. C. Mathieson		Mrs. S. Troll		
Millom		Mrs. M. Fazackerley (Relief)		
		Mrs. E. Lancaster (Surgery Nurse)		
		Mrs. V. Armstrong (Aux.)		
Dr. R. N. Galloway		Mrs. I. Routledge	Mrs. A. King	Mrs. S. Crellin
Dr. M. C. Nicolson		Mrs. H. Egan		Mrs. W. Batey
Dr. B. T. Higgins		Mrs. B. Tinnion (Relief)		
Dr. R. H. Pearson		Mrs. A. Keenan (Surgery Nurse)		
Whitehaven		Mrs. M. West	Mrs. A. King	Miss I. Alcock
Dr. R. W. Chalmers		Mrs. A. Graham (Relief)		
Dr. A. P. Timney			Mrs. A. King	Miss I. Alcock
Whitehaven		Mrs. M. Swinburne		
Dr. J. Gilmour		Mrs. I. Smith (Relief)		
Dr. B. Moss			Mrs. A. King	Miss A. Singleton
Whitehaven		Miss J. Woodend		
Dr. H. A. Fleming		Mrs. M. Vincent (Relief)		
Dr. J. G. Dickson				
Dr. E. Graham				
Whitehaven				
Dr. R. C. Macfarlane		Mrs. E. Brannon	Mrs. A. King	Mrs. A. Petch
Dr. K. R. Walker		Mrs. D. Cameron (Relief)		Miss E. Miller (Geriatric Visitor)
Whitehaven				

WESTERN AREA FAMILY HEALTH CARE TEAMS DECEMBER 1970

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. T. Fletcher	Miss A. I. Kirk		Mrs. M. Lythgoe
Dr. E. B. Herd	Miss M. Musgrave		Miss A. Dixon
Dr. D. E. Holloway Cockermouth	Mrs. V. Sherwood		
	Mrs. E. Swindle (Relief)	Miss A. Kirk	
	Mrs. J. Thomas (Relief)	Miss M. Musgrave	
	Mrs. K. Lytollis		
Dr. A. G. Graham Cockermouth	Mrs. M. E. Dobson (Relief)		Miss M. Reynolds
Dr. R. J. M. Irvine Cockermouth	Mrs. M. E. Dobson		Miss M. Reynolds
Dr. J. A. Harrow Keswick	Mrs. K. Lytollis (Relief)		Mrs. A. E. Campbell
Dr. J. D. Mitchell Keswick	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Miss M. Casey
Dr. T. Donaldson Keswick	Mrs. J. E. Barnes (Relief)	Miss M. Casey	Mrs. A. E. Campbell
Dr. I. F. Smith Keswick	Miss M. J. Cox (Relief)	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. H. Bird	Mrs. J. E. Barnes	Miss S. M. J. Iliffe	Mrs. L. Williams
Dr. S. A. W. Rattrie	Miss S. M. J. Iliffe	Miss O. Pickering	Miss A. Dixon (Relief)
Dr. K. Longstaff	Mrs. J. E. Barnes (Relief)	Miss A. Chadwick	
Dr. B. J. Havard	Miss O. Chadwick	Mrs. J. Bacon	
Dr. F. W. Clark	Mrs. J. Bacon		
Dr. C. M. Yule	Mrs. A. Irving		
Dr. K. M. A. Slinger Maryport	Mrs. E. Foster		
	Miss G. Whalley (Relief)		

General Practitioners

Dr. R. E. Fletcher
 Dr. R. H. Fletcher
 Dr. W. H. Fletcher
 Dr. A. Craig
 Workington
 Dr. D. N. Fitzgerald
 Workington
 Dr. N. McKerrow
 Dr. P. I. Rutherford
 Dr. K. A. Sugathan
 Dr. A. W. B. Lawson
 Workington
 Dr. J. Pavsey-Smith
 Dr. I. R. McLeod
 Workington
 Dr. C. Robinson
 Dr. M. A. Majahed
 Dr. W. D. Baston
 Workington
 Dr. G. M. Thomas
 Workington
 Dr. R. N. R. Grant
 Workington

Home Nurses

Mrs. J. Palin
 Mrs. L. Daniels (Relief)
 Mrs. M. I. Lewis
 Miss M. Young
 Mrs. D. Fisher
 Mrs. M. K. Tunstall
 Mrs. M. J. Spedding (Relief)
 Mrs. M. Hamilton
 Mrs. E. Fagan
 Mrs. K. I. Bell (Relief)
 Mrs. J. M. Brown
 Mrs. J. M. Potts
 Miss J. Cunliffe
 Mrs. M. I. Lewis
 Mrs. M. I. Lewis
 Mr. T. D. M. Holmes, Male Nurse
 Mr. T. G. Cartner, Male Nurse
 Mrs. M. B. White

Midwives

*Mrs. M. K. Tunstall
 Miss J. Cunliffe
 (Ante and Post Natal Care)

Health Visitors

Miss A. Jackson
 Mrs. M. Hewitson
 Miss E. J. Surtees
 Mrs. J. A. Graham
 Mrs. H. Watson
 Miss G. Davies
 Mrs. A. M. Wandless
 Mrs. J. V. Clark
 Mrs. J. V. Clark

Work with all Workington Practices

*Confinements covered by Workington Infirmary Hospital Staff.

ADMINISTRATION

The recommendations of a Working Party set up by the County Council to consider the Maud Report and revise the way in which business was transacted by the Council were brought into effect in 1970. Their purpose was to simplify the County administration.

The main effect of these changes on the health and welfare services was to change the title of the Health, Housing and Welfare Committee to Health and Welfare Committee; to dispense with two central sub-committees — General Purposes and Joint Health and Education; and to abolish the three area house sub-committees which had been responsible for the management of residential accomodation. In addition, the delegation of responsibility to chief officers was more clearly defined, the general aim being to ensure that committees concentrate their attention on matters of policy and principle and divest themselves of administrative detail.

Within this overall plan the day to day management of almost all aspects of the health and welfare services have been delegated to the three area medical officers, each of whom is responsible to an area health sub-committee for the smooth and efficient running of the services for a population of about 75,000. These area committees have a wide representation and include among their members hospital consultants, general practitioners, teachers and representatives of district councils. The members visit residential accommodation coming within their jurisdiction on a rota basis and report their findings to the area committees. Powers and responsibilities which have been delegated to me as chief officer of the department by the County Council have, where they relate to the day to day management of services, been further delegated to the area medical officers for the more efficient discharge of their duties.

The central Health and Welfare Committee includes representation from the Cumberland Executive Council and the Special Area Committee of the Regional Hospital Board, in addition to external members co-opted for their special interest in, and knowledge of, matters coming within the ambit of the committee. It

receives reports on their work from the area committees, and deals directly with matters relating to the ambulance and dental services and generally with policy, training and finance.

Undoubtedly the administration of the health and welfare services throughout this county is eased and made more effective by the ready co-operation of the other branches of the health service and voluntary organisations. There is an excellent liaison with them and this is greatly facilitated by cross representation on committees and groups.

There are active Local Maternity Liaison Committees in each of the two hospital management areas with my deputy acting as secretary. I, or my deputy, are able to attend meetings of the Special Area Committee of the Regional Hospital Board, the West Cumberland Hospital Management Committee, Garlands Medical Advisory Committee and the Cumberland Local Medical Committee. The Chief Nursing Officer is a member of the East Cumberland Hospital Management Committee.

There is a Health and Medical Services Liaison Group, membership of which is mostly professional and with representation from this authority, the Carlisle authority, the Special Area Committee, the Cumberland and Carlisle Executive Councils and the Cumberland and Carlisle Local Medical Committees. The group meets twice a year to discuss the effects of policy decisions and actions by one branch of the service on others. This could well be a most important group when plans for the unification of the health service get under way.

A bulletin is sent to general practitioners to keep them informed of the work of the department as circumstances warrant it.

The administration of the department has undergone a number of major changes in the past decade. The welfare service was amalgamated with the health service, there was complete integration of the mental health and welfare services, the ambulance service was changed from contractual arrangements to direct operation, and there was de-centralisation to area administration with a large measure of delegation to those concerned with day to

day management. Now we face the major re-organisation necessary to implement the Seebohm Report and establish a Social Services Department. At the same time we await the Government's consultative document on the future of the health service and undoubtedly it will mean more radical re-organisation in the future. The aim, therefore, must be to organise the existing service so as to make the transition to a unified health service as smooth as possible.

THE ADMINISTRATIVE AREAS OF THE COUNTY

Area	Area Medical Officer	Districts covered	Total Avoage	Total population	Births in 1970	Child Health				Part III			Sup. Ind. Places
						Centres	Attendances	Training	Centres	Places	Homes	Accom.	
Northern	Dr. C. A. Bentley, 13, Portland Square, Carlisle, CA1 1PZ.	Alston R.D.											
		Border R.D.											
		Penrith R.D.			1,094	13	7,822	1	45	8	190		159
		Penrith U.D.	612,000	76,360									
		Wigton R.D.											
Western	Dr. A. Hargreaves, Fieldside, Elizabeth Street, Workington.	Cockermouth R.D.											
		Cockermouth U.D.											
		Keswick U.D.	173,000	73,320	1,064	8	7,296	1	80	4	119		136
		Maryport U.D.											
		Workington M.B.											
Southern	Dr. H. M. Marks, Flatt Walks Clinic, Whitehaven.	Ennerdale R.D.											
		Millom R.D.	182,000	73,360	1,089	6	5,602	1	75	4	135		36
		Whitehaven M.B.											

GENERAL STATISTICS AND SOCIAL CONDITIONS OF THE AREA

The Registrar General's mid-year estimate of population for the county for 1970 was 223,040 which is 1,400 less than the mid-year estimate for 1969. There was a natural increase (births less deaths) of 518 persons, one of the lowest on record, which, according to the Registrar General indicates a total outward migration of some 1,918 persons during the year, a similar number to that of 1969 — as shown in the following table:—

Year	R.G's. Mid-year estimate of population	Natural Increase births less deaths	Nett migration (Persons)	
			In	Out
1962	223,330	1,362	508	—
1963	224,630	1,151	1,419	—
1964	225,690	1,477	—	417
1965	225,570	1,210	—	1,330
1966	225,260	909	—	1,219
1967	225,100	1,049	—	1,209
1968	225,700	611	—	11
1969	224,440	644	—	1,904
1970	223,040	518	—	1,918

In the past, one of the Registrar General's main sources of information for the mid-year estimates has been the electoral register. However, this year due to the lowering of the voting age, adjustments have had to be made to compensate for the inclusion of persons aged 18—20 years on the register, which, in areas where there has been considerable movement in the younger age groups over recent years, will have a marked influence on the estimates.

Vital Statistics

Births

The birth rate of 14.6 births per 1,000 total population is the lowest ever recorded, the number of births having fallen from 3,401

in 1969 to 3,247. This is not, however, the lowest annual birth figure recorded in the county. This was in fact 3,086 for 1939 and occurred in the pre-war period of numerically low births i.e., 1936-39.

There have been 49 stillbirths giving a rate of 14.9 stillbirths per 1,000 live and stillbirths; this is the highest rate for the past three years, and does not compare favourably with the provisional rate of 13.0 for England and Wales.

The high number of stillbirths has affected the perinatal mortality rate which is 25.2 stillbirths and first week deaths per 1,000 live and stillbirths. This compares with the county rate of 24.9 for 1969 but unfavourably with the provisional England and Wales rate of 23.5.

The infant mortality rate of 18.2 deaths of children under one year old per 1,000 live births is comparable with the county rate for 1969 and also with the provisional national rate of 18.2.

Maternal Mortality

There were no deaths associated with pregnancy this year. There have been no deaths in this category since 1967. During this period, 10,030 confinements have safely occurred to Cumbrian mothers.

Mortality

2,729 Cumbrians died this year, compared with 2,757 in 1969. The crude death rate is slightly lower at 12.2 deaths per 1,000 total population. As one can see from the crude death rates shown in the following table on "Births and Deaths Statistics" the rates over the past decade have remained fairly consistent, and I wonder if the limit for mortality reduction in the area has almost been reached. A recent technical report of a joint United Nations/World Health Organisation meeting on "Programmes of Analysis of Mortality Trends and Levels", stated — "There is clearly a limit to the extent to which we can expect mortality to decline in areas

where the risk of infectious diseases has become negligible". There will no doubt be fluctuations in the rates according to the severity of the winters but a major break-through in preventive medicine for cancer and cardiovascular disease is needed before any marked progress can be made.

There were fewer deaths from cancer of the lung — 106 against 118 for 1969, and the 93 deaths from bronchitis was a considerably lower figure than the 123 for 1969.

The decrease in the number of deaths from heart disease in 1969 (901) has not been maintained and there have been 952 such deaths this year; ischaemic heart disease accounting for 46 of the increase.

There has been a welcome decrease in the number of deaths from suicides and self-inflicted injuries over the past decade as shown by the following table:—

1961	1962	1963	1964	1965	1966	1967	1968	1969	1970
19	23	24	18	15	11	11	14	12	7

I have been studying the proportional mortality indicator for this area in an effort to determine the standard of health conditions. The indicator is simply the proportion of deaths at age fifty years and over to total deaths in the population. The following table shows the steady improvement in the England and Wales indicator since 1960, and the local figure, although subject to minor variations has maintained a similar upward trend. The most interesting feature is that in this county the index has been over 90% for four of the past five years.

% OF DEATHS OVER 50 YEARS 1960 - 1970

Year					Cumberland	England and Wales
1960	...	...	...	...	87.8	88.8
1961	...	...	...	...	89.6	89.2
1962	...	...	...	...	87.7	89.2
1963	...	...	...	...	89.4	89.5
1964	...	...	...	...	89.8	89.0
1965	...	...	...	...	89.5	89.5
1966	...	...	...	...	90.4	89.8
1967	...	...	...	...	90.1	89.8
1968	...	...	...	...	89.9	90.4
1969	...	...	...	...	90.7	Not available.
1970	...	...	...	...	90.1	Not available.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County — 967,054.

Rateable Value (April 1st, 1970) — £7,891,416.

Estimated Product of 1d. Rate (1970-71) — £31,204.

Population (Census 1951) — 217,540.

Population (Census 1961) — 223,202.

Population/1970 Mid-Year Estimate — 223,040.

Live Births — Number	...	...	...	...	3,247
Rate per 1,000 population	...	...	...	...	14.6
Illegitimate Live Births per cent of total births	...	...	...	...	6.4
Still Births — Number	...	...	...	...	49
Rate per 1,000 total live and still births	...	...	...	...	14.9
Total Live and Stillbirths	...	...	...	...	3,296
Infant Deaths (Deaths under 1 year)	...	...	...	...	59
Infant Mortality Rate—					
Total Infant Deaths per 1,000 total births	...	...	...	...	18.2
Legitimate Infant Deaths per 1,000 total legitimate births	...	...	...	...	18.4
Illegitimate Infant Deaths per 1,000 total illegitimate births	...	...	...	...	14.5
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	...	...	...	...	12.0
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births)	...	...	...	...	10.5
Perinatal mortality rate (Still Births and Deaths under 1 week combined per 1,000 total live and still births)	...	...	...	...	25.2
Maternal Mortality (including abortion) — Number of Deaths	...	...	...	...	—
Rate per 1,000 total live and still births	...	...	...	...	—

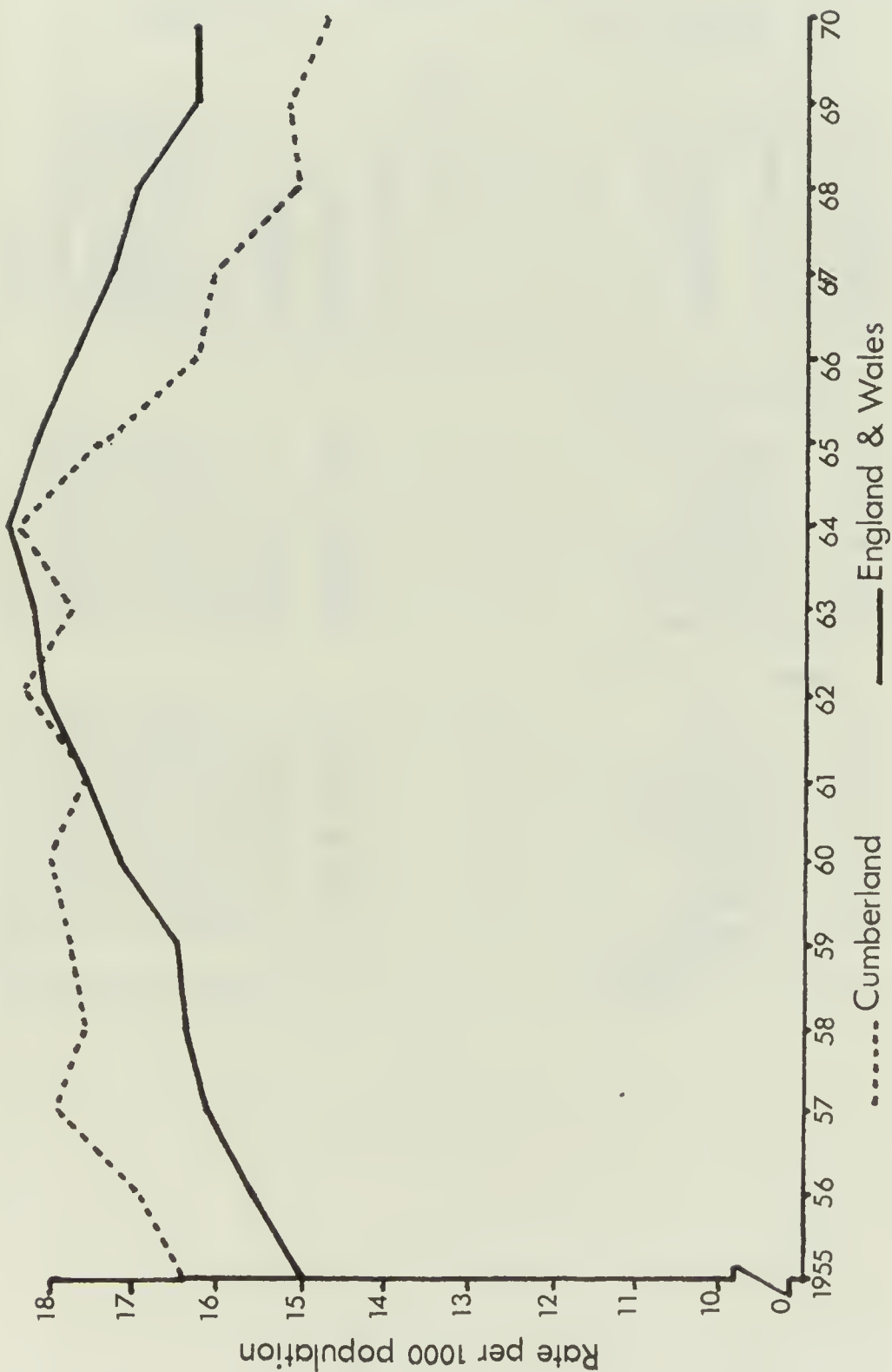
A more detailed analysis of the above figures is given overleaf

		Male	Female	Total	Urban Districts	Rural Districts	Admin. County	England & Wales
LIVE BIRTHS—								
Legitimate	...	1583	1457	3040				
Illegitimate	...	103	104	207				
		<hr/>						
		1686	1561	3247				
		<hr/>						
Birth rate per 1,000 population					15.2	14.1	14.6	16.0
STILL BIRTHS—								
Legitimate	...	29	17	46				
Illegitimate	...	1	2	3				
		<hr/>						
		30	19	49				
		<hr/>						
Still birth rate per 1,000 total births					14.4	15.2	14.9	13.0
DEATHS—								
All causes	...	1450	1279	2729				
Death rate per 1,000 population					12.5	12.1	12.2	11.7
INFANT DEATHS—								
All infants under 1 year of age—								
Legitimate	...	32	24	56				
Illegitimate	...	2	1	3				
		<hr/>						
		34	25	59				
		<hr/>						
Total infant deaths per 1,000 total live births					14.6	20.8	18.2	18.2

BIRTHS AND DEATHS STATISTICS

Year	Estimated mid-year population	Births:		Deaths.		Excess of births over deaths
		Number	Rate	Number	Rate	
1940	209,930	3,293	15.6	3,209	15.2	84
1960	219,160	3,940	18.0	2,629	12.0	1,311
1961	221,460	3,900	17.6	2,725	12.3	1,175
1962	223,330	4,085	18.3	2,723	12.2	1,362
1963	224,650	3,964	17.7	2,813	12.5	1,151
1964	225,690	4,147	18.4	2,670	11.8	1,477
1965	225,570	3,916	17.4	2,706	12.0	1,210
1966	225,260	3,670	16.3	2,761	12.3	909
1967	225,100	3,601	16.0	2,552	11.3	1,049
1968	225,700	3,400	15.1	2,789	12.4	611
1969	224,440	3,401	15.2	2,757	12.3	644
1970	223,040	3,247	14.6	2,729	12.2	518

LIVE BIRTH RATE 1955 - 1970 Cumberland and England & Wales



BIRTHS, DEATHS, INFANT MORTALITY AND POPULATION IN THE YEAR 1970

District	Births								
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor	Stillbirths	Stillbirth Rate		
URBAN DISTRICTS—									
Cockermouth	80	7	87	13.5	1.00	1	11.4		
Keswick	58	1	59	13.1	1.15	3	48.4		
Maryport	173	13	186	15.6	0.96	3	15.9		
Penrith	165	12	177	15.9	1.00	4	22.1		
Whitehaven	386	22	408	15.4	0.93	5	12.1		
Workington	426	25	451	15.3	1.00	4	8.8		
Aggregate	1288	80	1368	15.2	0.98	20	14.4		
RURAL DISTRICTS—									
Alston	33	1	34	16.3	1.25	—	—		
Border	362	27	389	13.0	1.12	2	5.1		
Cockermouth	261	20	281	13.4	1.02	4	14.0		
Ennerdale	470	28	498	15.6	0.99	7	13.9		
Millom	170	13	183	12.2	1.08	3	16.1		
Penrith	146	7	153	13.4	1.07	—	—		
Wigton	310	31	341	15.7	1.05	13	36.8		
Aggregate	1752	127	1879	14.1	1.05	29	15.2		
Administrative County	3040	207	3247	14.6	1.02	49	14.9		

			Deaths					Infant Mortality					Estimated Mid-year population
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	
72	11.2	1.08	2	1	1	2	2	23.0	23.0	23.0	3	34.1	6450
83	18.5	0.80	—	—	—	—	—	—	—	—	3	48.4	4490
166	13.9	1.12	6	6	—	3	3	32.3	16.1	16.1	6	31.8	11920
131	11.8	0.96	2	2	—	2	1	11.3	11.3	5.6	5	27.6	11140
329	12.4	1.18	4	4	—	3	3	9.8	7.4	7.4	8	19.4	26460
341	11.6	1.15	6	6	—	3	2	13.3	6.7	4.4	6	13.2	29460
1122	12.5	1.10	20	19	1	13	11	14.6	9.5	8.0	31	22.3	89920
30	14.4	0.82	2	2	—	—	—	58.9	—	—	—	—	2080
415	13.8	0.87	9	8	1	5	5	23.1	12.9	12.9	7	17.9	30020
243	11.6	1.09	4	4	—	3	3	14.2	10.7	10.7	7	24.6	21000
339	10.6	1.24	14	14	—	9	7	28.1	18.1	14.1	14	27.7	31940
147	9.8	1.28	3	3	—	3	3	16.4	16.4	15.4	6	32.3	14960
131	11.4	1.05	1	1	—	1	1	6.5	6.5	6.5	1	6.5	11450
302	13.9	0.92	6	5	1	5	4	17.6	14.7	11.7	17	48.0	21670
1607	12.1	1.04	39	37	2	26	23	20.8	13.8	12.2	52	27.2	133120
2729	12.2	1.06	59	56	3	39	34	18.2	12.0	10.5	83	25.2	223040

PERINATAL DEATHS 1956-1970

Year	Stillbirths	Early Neo-natal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal Deaths per 1,000 total births	
				Cumberland	E'land & Wales	Cumberland	E'land & Wales
1956	111	64	175	29.3	22.9	46.2	36.7
1957	102	64	166	25.5	22.5	41.5	36.2
1958	80	69	149	20.4	21.5	38.1	35.0
1959	83	54	137	20.9	20.8	34.5	34.1
1960	111	60	171	27.4	19.8	42.2	32.8
1961	76	53	129	19.1	19.0	32.4	32.0
1962	78	71	149	18.7	18.1	35.8	30.8
1963	76	60	136	18.8	17.2	33.7	29.3
1964	77	47	124	18.2	16.3	29.4	28.3
1965	80	37	117	20.0	15.8	29.3	26.9
1966	60	40	100	16.1	15.4	26.8	26.3
1967	70	38	108	19.1	14.8	29.4	25.4
1968	44	36	80	12.8	14.3	23.2	24.7
1969	47	39	86	13.6	13.2	24.9	23.4
1970	49	34	83	14.9	13.0	25.2	23.4

CAUSES OF DEATH

		Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.	Whitehaven M.B.	Workington M.B.	Aggregate of U.D.'s	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D.'s.
	ALL CAUSES	2,728	72	83	166	130	329	341	1,121	30	414	243	339	147	133	301	1,607
B4	Enteritis and other Diarrhoeal Diseases	1	—	—	—	—	—	1	1	—	—	—	—	—	—	—	—
B5	Tuberculosis of Respiratory System	2	—	—	—	—	—	1	1	—	—	—	—	—	—	1	1
B6(1)	Late effects of Respiratory T.B.	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
B6(2)	Other Tuberculosis	2	—	—	—	—	—	1	1	—	—	—	1	—	—	—	1
B17	Syphilis and its Sequelae	1	—	—	—	—	—	1	1	—	—	—	—	—	—	—	—
B18	Other Infective and Parasitic Diseases	6	—	—	—	1	1	—	2	—	2	—	—	—	2	—	4
B19(1)	Malignant Neoplasm, Buccal Cavity, etc.	10	—	—	—	—	—	2	2	—	—	—	4	1	—	3	8
B19(2)	Malignant Neoplasm, Oesophagus	16	—	1	—	2	1	4	8	—	1	2	2	1	—	2	8
B19(3)	Malignant Neoplasm, Stomach	72	3	1	2	2	9	10	27	—	8	9	8	3	3	14	45
B19(4)	Malignant Neoplasm, Intestine	91	7	1	4	2	12	14	40	—	14	7	14	5	6	5	51
B19(5)	Malignant Neoplasm, Larynx	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1
B19(6)	Malignant Neoplasm, Lung, Bronchus	106	2	4	8	7	19	15	55	1	13	9	16	5	—	7	51
B19(7)	Malignant Neoplasm, Breast	36	—	2	2	3	2	6	15	—	4	3	4	1	2	7	21
B19(8)	Malignant Neoplasm, Uterus	16	1	1	3	—	—	3	8	—	4	—	1	1	1	1	8
B19(9)	Malignant Neoplasm, Prostate	15	—	1	4	1	—	2	8	—	1	1	1	—	—	4	7
E19(10)	Leukaemia	9	—	—	—	—	1	—	1	—	1	2	1	1	1	2	8
E19(11)	Other Malignant Neoplasms	123	6	1	8	5	12	17	49	2	16	13	15	8	11	9	74
B20	Benign and Unspecified Neoplasms	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
B21	Diabetes Mellitus	21	1	—	1	1	4	2	9	1	1	2	4	1	1	2	12
B22	Avitaminoses, etc.	2	1	—	—	—	—	—	1	—	—	—	—	1	—	—	1
B46(1)	Other Endocrine etc. Diseases	6	1	—	1	—	1	—	3	—	1	—	—	2	—	—	3
B23	Anaemias	6	—	—	1	1	1	—	3	—	1	—	1	—	—	1	3
B46(3)	Mental Disorders	2	—	—	—	1	—	—	1	—	—	—	1	—	—	—	1
B24	Meningitis	2	1	—	—	—	1	—	2	—	—	—	—	—	—	—	—
B46(4)	Multiple Sclerosis	7	—	—	—	1	4	—	5	—	—	—	—	1	—	1	2
B46(5)	Other Diseases of Nervous System	21	—	—	1	1	4	2	8	—	2	1	4	—	—	6	13
B26	Chronic Rheumatic Heart Disease	42	1	1	3	—	5	6	16	1	7	3	8	2	2	3	26
B27	Hypertensive Disease	52	2	2	5	—	5	3	17	—	13	5	7	3	4	3	35
B28	Ischaemic Heart Disease	794	14	16	49	47	97	113	336	8	120	63	106	39	38	84	458
E29	Other forms of Heart Disease	106	1	9	4	8	7	17	46	—	14	14	9	5	3	15	60
B30	Cerebrovascular Disease	458	11	25	27	21	44	45	173	3	77	46	49	28	33	49	285
B46(6)	Other Diseases of Circulatory System	115	3	3	5	2	18	15	46	1	23	12	13	6	2	12	69
B31	Influenza	37	1	1	1	1	3	4	11	—	10	2	1	7	—	6	26
B32	Pneumonia	103	4	2	9	2	11	9	37	2	29	10	11	4	3	7	66
B33(1)	Bronchitis and Emphysema	93	4	4	5	3	12	9	37	2	13	7	20	1	6	7	56
B33(2)	Asthma	10	—	1	1	—	2	1	5	1	1	—	—	—	—	3	5
B46(7)	Other Diseases of Respiratory System	38	—	2	5	—	10	5	22	2	2	2	4	1	—	5	16
B34	Peptic Ulcer	13	1	—	—	1	2	—	4	—	1	1	4	1	—	2	9
B35	Appendicitis	1	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1
B36	Intestinal Obstruction and Hernia	9	—	—	—	2	—	—	2	1	1	2	—	1	—	2	7
B37	Cirrhosis of Liver	8	—	—	1	—	1	—	2	—	2	1	2	1	—	—	6
B46(8)	Other Diseases of Digestive System	25	—	1	3	—	2	1	7	—	1	2	5	3	—	7	18
B38	Nephritis and Nephrosis	20	2	—	1	1	4	2	10	—	4	1	—	—	—	5	10
B39	Hyperplasia of Prostate	9	—	—	1	—	—	2	3	1	—	1	1	—	—	3	6
B46(9)	Other Diseases, Genito-Urinary System	16	—	—	1	1	1	4	7	—	3	2	—	2	1	1	9
B46(10)	Diseases of Skin, Subcutaneous Tissue	1	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1
B46(11)	Diseases of Musculo-Skeletal System	12	2	—	1	1	1	1	6	—	—	1	1	—	2	2	6
B42	Congenital Anomalies	16	1	—	2	—	—	2	5	—	4	1	3	—	—	3	11
B43	Birth Injury, Difficult Labour, etc.	13	—	—	2	1	3	2	8	—	—	1	1	1	—	2	5
B44	Other Causes of Perinatal Mortality	15	1	—	—	—	—	—	1	—	3	2	5	2	1	1	14
E45	Symptoms and Ill Defined Conditions	38	—	—	—	3	18	4	25	1	—	3	4	—	2	3	13
BE47	Motor Vehicle Accidents	36	—	1	—	6	2	2	11	1	8	5	1	1	6	3	25
BE48	All Other Accidents	59	—	2	5	2	9	10	28	1	6	5	6	7	1	5	31
BE49	Suicide and Self-Inflicted Injuries	7	1	—	—	—	—	3	4	—	1	—	—	—	1	1	3
BE50	All other External Causes	6	—	1	—	—	—	—	1	—	1	1	1	1	1	—	5

MORTALITY TRENDS IN CUMBERLAND

Year	Under 1	1—	5—	15—	25—	45—	65—	75+	Total
1930	214 8.4%	85 3.3%	79 3.1%	103 4.0%	253 9.9%	607 23.8%	586 23.0%	624 24.5%	2,551 Rate 12.2
1940	245	109	52	102	244	745	848	864	3,209 Rate 15.2
1950	134	28	21	52	177	562	695	1,047	2,716 Rate 12.6
1960	91	13	19	21	105	554	677	1,149	2,629 Rate 12.0
1961	88	7	19	19	86	570	747	1,189	2,725 Rate 12.3
1962	108	15	13	15	114	574	759	1,125	2,723 Rate 12.1
1963	87	8	11	33	97	648	721	1,208	2,813 Rate 12.5
1964	76	19	14	24	88	626	705	1,118	2,670 Rate 11.8
1965	66	11	13	29	89	618	750	1,130	2,706 Rate 12.0
1966	77	6	13	25	96	588	732	1,224	2,761 Rate 12.3
1967	2.8%	0.2%	0.5%	0.9%	3.5%	21.3%	26.5%	44.3%	2,552 Rate 11.3
1968	61	7	11	29	84	593	696	1,071	2,789 Rate 12.4
1969	2.4%	0.3%	0.4%	1.1%	3.3%	23.2%	27.3%	42.0%	2,757 Rate 12.3
1970	66	9	16	28	100	632	789	1,149	2,729 Rate 12.2
	2.4%	0.3%	0.6%	1.0%	3.6%	22.6%	28.3%	41.2%	
	64	9	13	19	71	631	792	1,158	
	2.3%	0.3%	0.5%	0.7%	2.6%	22.9%	28.7%	42.0%	
	59	9	8	19	93	591	766	1,182	
	2.2%	0.3%	0.3%	0.7%	3.4%	21.7%	28.1%	43.2%	

CUMBERLAND COUNTY PERINATAL DEATHS

(locally compiled figures)

Analysis of Causes of Perinatal Deaths during 1970

<i>Cause of Death</i>	<i>Stillbirths</i>		<i>Deaths during</i>	
	<i>Premature</i>	<i>Full-time</i>	<i>1st Week</i>	<i>Total</i>
Toxaemia	3	1	2	6
Ante Partum Haemorrhage ...	3	2	5	10
Placental Insufficiency	5	3	2	10
Rhesus Factor	3	1	—	4
Maternal Diabetes	—	—	—	—
Prematurity	3	—	5	8
Congenital Malformations (including Congen. Heart)	7	2	5	14
Tentorial Haemorrhage	—	1	3	4
Asphyxia—				
Prolapse of cord (including separation of cord)	—	—	1	1
Cord round neck + true knot in cord	—	—	1	1
Intra Uterine	2	1	—	3
Pneumonia (inhalation) ...	—	—	1	1
Anoxia	—	—	1	1
Atelectasis	1	1	5	7
Cerebral Haemorrhage	—	—	—	—
No known cause	1	2	—	3
Malpresentation	—	—	—	—
Maceration	2	—	—	2
Post Maturity	—	3	—	3
Maternal Influenza	—	1	—	1
Maternal Pancreatitis	—	—	1	1
Exomphalos	—	—	1	1
Outstanding Forms	1	—	1	2
TOTAL:	31	18	34	83

INFANT MORTALITY

<i>Cause of Death</i>	<i>Age in Weeks</i>			<i>Total</i>
	<i>Under 1</i>	<i>1 to 4</i>	<i>4 to 52</i>	
Prematurity	5	—	—	5
Toxaemia	2	—	—	2
Congenital Malformations (including Congen. Heart).	5	4	3	12
Asphyxia	4	—	1	5
Atelectasis	5	—	—	5
Pneumonia and Bronchitis	—	—	7	7
Ante Partum Haemorrhage .. .	5	—	—	5
Meningitis	—	1	—	1
Placental Insufficiency	2	—	—	2
Tentorial Haemorrhage	3	—	—	3
Maternal Pancreatitis	1	—	—	1
Exomphalos	1	—	—	1
Accidental Deaths	—	—	3	3
Other Causes	—	—	2	2
Forms O/S	1	—	4	5
	<hr/> 34	<hr/> 5	<hr/> 20	<hr/> 59

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales for 1961 to 1970 are as follows:—

<i>Year</i>	<i>Rates per 1,000 total live births</i>	
	<i>Cumberland</i>	<i>England and Wales</i>
1961 ...	22.6	21.4
1962 ...	26.4	21.7
1963 ..	22.0	21.1
1964 ...	18.3	19.9
1965 ...	16.9	19.0
1966 ...	21.6	19.0
1967 ...	16.9	18.3
1968 ...	19.4	18.3
1969 ...	18.8	18.1
1970 ...	18.2	18.2

NURSING SERVICES

Sections 23, 24 and 25 of the National Health Service Act, 1946

“It shall be the duty of every local health authority to secure, whether by making arrangements with the Board of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority’s area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period of not less than the lying-in period, is adequate for the needs of the area.

It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors to be called “health visitors”, for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own home.”

THE COMMUNITY NURSING SERVICE

It is now almost four years since the final completion of attachment of nursing staff to general practitioners. This system is continually being assessed as new patterns of work develop and new needs arise in the community. It is also necessary to discuss in particular the nurse's role and position in the team.

Community nurses are still developing the team approach to patient and family care, working alongside their general practitioner and social work colleagues. Team work can sometimes be a traumatic experience for nurses and doctors who have for many years worked in isolation. It takes time to understand each other's role and skills as it takes time to subdue personal prejudices and to build up mutual trust. Until this can be achieved by all members of a team, skills and responsibilities are under-used and vital energy is lost.

Suitable accommodation with adequate consulting and treatment rooms, office and reception space also helps towards integration — the team working together under one roof. This unfortunately is only possible to the fullest extent at the moment in one or two centres in the county.

I trust that by in-service training, support and encouragement, not only technical skills will be developed but also the ability will grow to recognise and seek out 'at risk' groups in the general practice population, so that adequate care may be provided and preventive measures may be pursued by all the nursing staff. I also hope to achieve better communications with the nursing and medical staffs within the Hospital Management Committee groups in the county in an effort to create a real continuity of patient care. Meetings have been arranged during the year to discuss this very complicated problem.

In January of this year, final arrangements were completed whereby the Roxburghshire nurse attached to the general practitioner at Newcastleton followed the care of the practice patients living in Cumberland. This attachment scheme has gone well

and the nurse has been able to give good continuing care to the population living in the Border region. There have also been ongoing discussions regarding the borders between Cumberland and Northumberland, and it is hoped at the beginning of 1971 to provide continuing care of patients belonging to the Brampton practice but living in Northumberland.

Good management and training must eventually solve some of these difficulties. Following publication of the Mayston Report on Management Structure in the Local Authority Nursing Services, many meetings and discussions have taken place regarding an appropriate nurse management structure for the county nursing service. There is no doubt that proper management techniques are needed not only in industry but in the National Health Service to ensure that all the resources are used to the full in an effort to give the best possible patient and family care. The Mayston Report recommended that management training should be given to all nurses in administrative posts (and to nurses preparing for such posts). To this end, arrangements have been made for group advisers to attend first line management courses at the Carlisle Technical College, and West Cumberland College of Technology and Science. During 1970, five nurses attended and more will attend further courses in 1971. Two of my senior nursing officers attended a middle management course in 1970.

Throughout 1970 in-service training of nursing staff has continued. Monthly staff lectures have been held, and I am indeed grateful to my consultant and general practitioner colleagues for their help in this training. In this technological age changes are continually taking place in the medical and nursing field, and it is important that all staff should keep up to date and informed of such changes.

Special study days have also been held — for health visitors, group advisers, practical work instructors, district nurses and school nurses. Hospital and community nursing staff have planned some of these sessions together, and hospital nursing staff have been welcomed at many of the lectures. Hospital student nurses have spent days with the community health care teams, gaining a wider

understanding of community services. It is anticipated that in the future, part of general nurse training will be based in the community, and to this end a further course for practical work instructors is planned for 1971.

Senior nursing officers from U.S.A., India and Denmark have visited the county during 1970 and expressed great interest in our services.

‘ RETURN TO NURSING ’ CLUBS

These clubs have continued to be run in the three areas of the county for married, registered nurses wishing to keep contact with new medical and nursing trends. An advertisement in January asking married nurses who wished to keep up to date with new medical and nursing techniques, and to hear about the community health care teams, brought in 47 replies and there have been other enquiries throughout the year.

Nine lectures have been arranged on clinical, nursing and medical subjects in each area and have been well supported. Out of a total membership of 136 an average of 18 members attended each session. In December all three clubs had successful dinner parties.

The clubs remain a useful recruitment pool both for the community and the hospital services: six members are now working as part-time or relief nurses in the county.

HOME AND SURGERY NURSING

The service has been well staffed throughout the year with the help of many part-time and relief nurses. The total number of visits continues to rise as do the number of treatments carried out in general practitioner surgeries.

These figures show the increasing trend for home nurses to be involved in other age groups in the population, due to the carrying out of follow-up visits for the general practitioners especially during 'flu outbreaks and also for infectious diseases. There is also a trend for patients to be discharged from hospital earlier and for appropriate nursing treatments to be carried out by the community nursing staff rather than the patient trailing back to the hospital for these treatments.

There is a slight rise in the number of new cases over 65, but a marked increase in the number of return visits to this age group. This is to be expected as the proportion of elderly in the population increases.

Three bath attendants are now in post and work under the supervision of home nurses. They have been most helpful in bathing care and have relieved the registered nurse for other duties. It is hoped to increase the number of bath attendants in the future.

The number of sessions where nurses are working in surgeries have increased during the year. Ideally I would hope these sessions could be arranged in each general practice, but unfortunately surgery premises do not always allow of this work, which in turn means unnecessary home visiting on the part of the nurse or unnecessary journeys for the patient to hospital laboratories and out patients, not to mention general practitioners themselves carrying out nursing procedures — injections, dressings, venepuncture, E.C.G. etc. Pre-sterilised dressing packs are used to a large extent by the home nurses and 'hibitane' and spirit now used for the sterilisation of instruments. We have finally left behind the age of biscuit tins baked in the oven and instruments boiled up in tea cups. We shall hope in the near future to provide all nurses with pre-packed and sterilised equipment.

Total No. of persons nursed	1967	1968	1969	1970
...	6,331	7,891	10,155	10,311
Aged under 5 years	...	361 (5%)	414 (5%)	451 (5% of total)
Aged over 65 years	...	3,516 (56%)	4,153 (53%)	4,825 (46% of total)
Other age groups	...	2,454 (38%)	3,324 (42%)	5,035 (49% of total)
Total No. of nursing visits	...	172,415	177,360	207,707

Total visits to aged over 65 years and other groups.

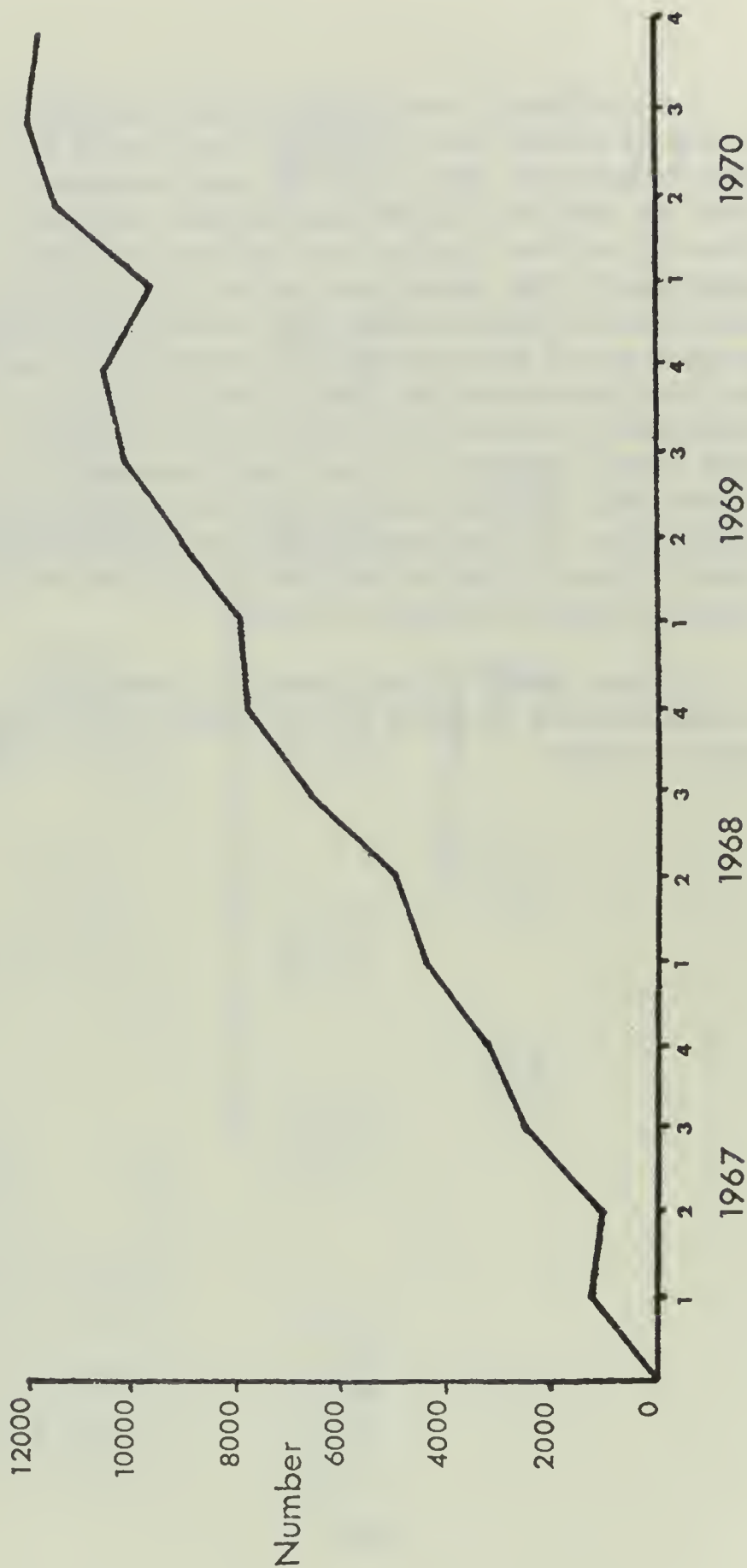
	1965	1966	1967	1968	1969	1970
Over 65's visits	97,834	107,933	113,747	130,979	146,107	156,503
Other groups	52,822	54,051	58,668	46,381	51,483	51,172

Surgery Treatments			
1967	1968	1969	1970
8,007	23,935	37,639	44,721

A fourth District Nurse Training Course was held in 1970, training 23 students, and bringing the total number of district nurses trained since 1968 to 75 (with only one failure). This course was held at the Cumberland Infirmary, and was a pilot scheme in that State Enrolled and State Registered nurses were trained side by side, sharing some of their lectures and having other lectures in separate groups. This course proved to be most successful and all the nurses passed their final examination. The State Enrolled nurses took the Queen's Institute of District Nursing examinations, and one of them gained the only distinction in the whole country. As well as nurses from Cumberland the course was also taken by nurses from Westmorland, Dumfries and Kirkcudbrightshire. A prize-giving was held at the Salkeld Hall, Cumberland Infirmary, in October, and Miss Ashton, from the Queen's Institute, presented certificates to the nurses.

Fifty-nine nurses (51 State Registered nurses and 8 State Enrolled nurses) in the county have now taken district training in the last two years.

QUARTERLY SURGERY TREATMENTS GIVEN BY NURSING STAFF



Marie Curie Memorial Foundation

Despite the fact that many patients are nursed at home with terminal carcinoma, only seven families asked for extra nursing aid from this Fund. Families do shoulder enormous responsibilities for these patients as do the Authority's district nurses, but where extra aid is needed it has been a great comfort. Thirteen patients have also been helped by grants for food, heating, clothing and bedding. This has been a total cost of over £400 to the Foundation and it is anticipated that the local authority may well be asked to contribute a percentage of the cost in the future.

As a broader issue I have been considering special nursing care for patients with terminal illness other than cancer.

Midwifery

The provision of a domiciliary midwifery service adequate for the needs of the area continues to be more and more difficult. During the year only 156 babies have been born at home — this out of a total number of 3,247 births, which means that over 95 per cent of babies were born in hospital.

To give adequate cover of domiciliary midwives for this very small number there was one full time midwife and 34 district nurse/midwives, many of whom had very few deliveries during 1970, and in fact seven had none.

TABLE I.

Y e a r	No. of births over past 5 years		Percentage of domiciliary births		Number of Mtdwives (domiciliary) in County	Full-time equiv- alent
	Total No. of births	Instit- utional births	Domic- iliary births	In county		
1966	3,719	3,158	561	14
				By Areas		
				N 17%	40	
				S 18%		
1967	3,662	3,234	428	13½
				W 10%		
				N 12%	36	
				S 14%		
1968	3,448	3,147	301	11½
				W 9%		
				N 10%	36	
				S 10%		
1969	3,480	3,254	226	8
				W 6%		
				N 6%	33	
				S 7%		
1970	3,427	3,091	156	7½
				W 4%		
				N 6.2%	33	
				S 4.7%	(As at	
				W 3.5%	31.12.70)	

Number of deliveries conducted by domiciliary midwives during 1970:

7 district nurse/midwives	...	...	Nil
20 district nurse/midwives delivered	...	...	5 (and under)
5 district nurse/midwives delivered	...	...	8 (and under)
1 full time midwife delivered	...	...	10
1 district nurse/midwife delivered	...	...	11
1 district nurse/midwife delivered	...	...	24

The full time midwife resigned in September and has not been replaced; one district nurse/midwife resigned and was not replaced; two district nurse/midwives are responsible for antenatal and post natal care only, midwives based at Workington Infirmary carrying out the home deliveries.

Hospital midwives in the Workington agency scheme delivered 9 mothers in their home.

It is interesting to note that 17 babies were delivered in ambulances during their journey to hospital centres. The reason for this increase in such births is not clear and is being investigated.

Not only have the total numbers of home confinements decreased but a matter for concern is the proportion of these, as is shown in Table II below, who by the criteria of age and parity were considered by modern practice to be 'at risk'. The obvious fact is that domiciliary midwives, having little practice in using the technical skills of delivery, are attending, with the general practitioners, mothers at home, who by accepted obstetric and midwifery criteria should be confined in hospital for their own safety, and the safety of their babies.

TABLE II.

Mothers booked for home confinements.

Area	At risk by age*		Complications
	Total number and parity		
South	52	20	1 Still Birth. 1 Premature baby admitted to hos- pital — died at 5 weeks.
West	37 (including 9 agency)	19	1 Admitted to hospital — Rhesus negative. 2 Births before arrival of midwife. 1 Admitted to hospital — post maturity.
North	70	48	3 Perinatal deaths (includes 2 still- births). 1 Admitted to hospital during premature labour with a breech presentation. 1 Premature baby — admitted to hospital. 1 Retained placenta — mother admitted to hospital for manual removal. 3 Births before arrival of midwife.

— *Age — over 35 years or under 18 years.

159 Parity — primipara or fourth and subsequent pregnancy

Another disquieting situation is the fact that some mothers are having an inadequate period of antenatal care — many of them booking for care by the hospital based doctors and midwives and general practitioner and midwife well after the fourth month of pregnancy. This unsatisfactory situation is reflected in the perinatal mortality rate which continues to be above national average.

I give below further data on work carried out by domiciliary midwives:

Total number of new mothers seen by the midwife at antenatal sessions held in G.P. surgeries	...	820
Number of these mothers booking after the fourth month of pregnancy	... ..	407
Number of new mothers attending classes (252 booked for hospital 22 booked for home)	... ..	274
Total attendances	... ..	1,540

At the end of 1970 there were 12 courses being held throughout the county for expectant mothers to teach relaxation and mothercraft methods apart from hospital based sessions.

We do hope 1971 will see more mothers, especially those having first babies, taking advantage of this special training to prepare them for childbirth.

TABLE III.

Midwifery Visits

Year	Antenatal visits paid to mothers at home (domiciliary and hospital bookings).	Postnatal visits to mothers delivered at home
1968	5,066	5,736
1969	5,346	4,492
1970	5,853	3,253

There is a slight rise in the number of mothers discharged from hospital within 48 hours of delivery and a decrease in other early discharges. This may be due to the fall in the total number of births and the lack of pressure on hospital beds in this county.

Early Discharges of Mothers from Hospitals

Year	No. of Mothers discharged within 48 hours.	No. of Mothers discharged 2nd — 8th day	Total number of visits to Mothers discharged before 10th day.
1968	—	1,267 (includes within 48 hrs.)	3,866
1969	146	1,117	4,630
1970	162	1,028	4,361

There were no maternal deaths in 1970 and this reflects, in the main, upon the great skill and care being taken in the hospital maternity units and by the obstetricians in charge. However, the perinatal mortality rate continues to be above the national average. I hope 1971 will see the lowering of this loss of babies, a more positive approach to all aspects of antenatal care, and hospital confinement of the 'at risk' mothers.

Since June 1969, midwives in the Workington Infirmary have acted as agents for domiciliary deliveries in the Workington area.

I am indebted to Miss Blake, Midwifery Superintendent, Workington Infirmary, for the following comments on the Agency Service provided for domiciliary midwifery:—

“It is now approaching two years since we embarked upon our new venture, providing an Agency Scheme whereby the hospital midwife attends confinements in the patients' own homes.

During the last twelve months the home confinement rate has shown a further decline in the Workington area. Of thirteen patients booked through the agency in 1970 only nine have ultimately been confined in their own homes. Of the remaining four bookings three patients were admitted to hospital for obstetric reasons. The fourth patient was admitted owing to staffing difficulties. In view of labour not being well established it was not possible for one midwife to spend several hours awaiting events at the patient's home and there was no alternative but to bring the patient into hospital. This was accepted by the patient quite well. A baby girl weighing 4.100 kg. arrived normally six hours after admission. Labour was complicated by a post partum haemorrhage. Mother and Baby were both discharged home to the care of the district midwife, 18 hours after delivery.

It has been our experience to find that patients booked for home confinement are willing to come into hospital when the reason for their admission has been fully explained to them. This may be due to the fact that over a few weeks they have got to know the hospital midwives and also the patient is told that

she can return home within 48 hours, if all goes well. We have only cared for one "at risk" patient over the past two years who refused point blank to take this advice, but however her confinement took place at home quite normally without the expected complications.

Since the commencement of Integrated Midwifery Training, we can now allow the pupil midwife working in the Workington area to care for our home-booked patients and deliver them at home under the supervision of the hospital midwife. Whenever possible the pupil attends the patient for antenatal visits along with the hospital midwife and then cares for her in the post natal period and this allows some continuity of care. This scheme also provides a further contribution towards the training of pupil midwives during their district training and at the same time is an added measure of safety for the patient and the midwife with two professional people being in attendance."

STUDENT MIDWIFERY TRAINING

Integrated midwifery training schemes are taking place in East and West Cumberland, based at the City Maternity Hospital, Carlisle, and at the West Cumberland Hospital. Students from these courses each spend 12 weeks in the community, during which time they are given a very wide view of all care available in the community, both from statutory and voluntary bodies. Students from the City Maternity Hospital do part of this community training in the county and the remainder in the City of Carlisle. Because of the low domiciliary midwifery rate the student midwives gain very little experience in actual home deliveries. They are given good experience in ante and post natal care with the teaching midwife, as well as general nursing care with the district nurse. These nurses also spend a considerable time with the health visitors, at which stage they are asked to write a case history on a family of interest — normally one with problems. Visits with the social workers, child care officers and public health inspectors are included in the programme as well as a study of special accommodation for the aged, physically and mentally handicapped children and adults, special schools, play groups etc.

During their time in the community the students have a weekly study day, and a recent innovation, which has proved most successful, has been the joining together of students from both hospitals for some of their study days. This gives a larger group for teaching and discussion purposes while the students enjoy meeting their colleagues and exchanging views. The course ends in a written paper and a general assessment.

We are most grateful to our hospital colleagues for the hospitality shown to the nursing officers when they teach at these study days in the two hospitals.

The nursing officers have also acted as examiners at the final hospital examinations for these students. Miss Byatt, Deputy Chief Nursing Officer, is an examiner for the Central Midwives Board and during the year has examined midwives for their final State examinations at Newcastle upon Tyne.

Miss Snelling, Educational Supervisor for the Central Midwives Board, has visited the integrated schemes during the year and has looked at the community training given. She has been very satisfied with both schemes.

Staff Training.

Four midwives attended the statutory refresher courses in 1970. Twenty-two midwives and health visitors attended in-service training courses in psychoprophylaxis to help them in the teaching of this and general relaxation methods, to antenatal mothers and fathers.

Stillbirths, Early Neonatal Deaths and Perinatal Deaths by Districts of Administrative County

	Stillbirths			Early Neonatal Deaths							Perinatal Deaths							
	1965	1966	1967	1968	1969	1970	1965	1966	1967	1968	1969	1970	1965	1966	1967	1968	1969	1970
Northern Area																		
Alston R.D.	—	—	2	—	—	—	1	—	—	—	—	—	1	—	2	—	—	—
Border R.D.	15	5	5	5	4	2	5	5	6	2	13	5	20	10	11	7	17	7
Penrith U.D.	2	5	2	4	1	4	—	1	—	—	—	—	1	2	6	2	4	1
Penrith R.D.	7	3	7	2	1	—	2	3	1	—	4	1	9	6	6	8	2	5
Wigton R.D.	7	7	9	3	11	13	7	4	2	4	4	4	14	11	11	7	15	17
Western Area																		
Workington M.B.	10	12	10	6	7	5	5	7	4	5	1	2	15	19	14	11	8	7
Maryport U.D.	5	3	6	6	2	3	1	—	3	1	2	2	6	3	9	7	4	5
Keswick U.D.	—	1	—	1	1	3	—	3	2	—	2	—	—	4	2	1	3	3
Cockermouth U.D.	4	3	1	—	1	1	—	—	2	1	—	2	4	3	3	1	1	3
Cockermouth R.D.	7	2	8	2	5	4	2	2	1	6	2	3	9	4	9	8	7	7
Southern Area																		
Whitehaven M.B.	7	4	9	4	4	5	5	4	7	5	4	3	12	8	16	9	8	8
Ennerdale R.D.	10	13	9	10	8	6	9	11	9	9	5	7	19	24	18	19	13	13
Millom R.D.	6	2	2	1	2	3	—	—	1	3	2	3	6	2	3	4	4	6
TOTAL	80	60	70	44	47	49	37	40	38	36	39	33	117	100	108	80	86	82

Notifications of Congenital Malformations

The notification to the Registrar General of all congenital malformations noticed at birth has continued since its inception in January 1964, in accordance with instructions from the then Ministry of Health, and now under the auspices of the Department of Health and Social Security, although in Cumberland a comprehensive register was kept of all congenital malformations in 1963, the previous year. This was done by means of health visitors' reports and death returns together with some help from the paediatrician.

During 1970, 47 cases of congenital malformation were notified compared with 49 cases during 1969. Since the scheme began most of these defects are accounted for under "The Central Nervous System, and Limbs"; most limb defects are those classified as talipes.

Computerisation of birth records began in 1970, and as the birth notification card incorporates all information necessary for completion of returns to the Registrar General, any cards which show details of congenital malformations are first photographed, and the copies immediately sent to the County Medical Officer of Health for the compilation of Form S.D.56.

The following table gives a breakdown of the total congenital malformations notified since 1964.

	Males		Females		Total	Total
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Total cases notified	170	30	155	41	325	71
Central nervous system	28	25	36	38	64	63
Eye, ear, etc.	5	—	5	—	10	—
Alimentary system	21	—	15	2	36	2
Heart and great vessels	6	—	6	—	12	—
Respiratory system	1	—	1	—	2	—
Uro-genital system	34	—	2	—	36	—
Limbs	56	1	63	—	119	1
Other skeletal	4	—	2	—	6	—
Other systems	10	1	10	—	20	1
Mongolism	3	2	12	—	15	2
Other malformations	2	1	3	1	5	2

Prematurity

A premature infant is a live born infant with a birth weight of 5 lbs. 8 ozs. (2.5 kilogrammes) or less.

The percentage of premature live births of total live births is 7%.

Premature births notified during 1970 as set out below with the previous four years for comparison.

1. Number of premature live births notified:—	1966	1967	1968	1969	1970
(a) in hospital	218	222	212	178	219
(b) at home	22	10	19	9	5
(c) in private nursing homes ...	—	—	—	—	—
	240	232	231	187	224
2. Number of premature stillbirths notified:—					
(a) in hospital	34	51	31	22	30
(b) at home	3	3	1	—	1
(c) in private nursing homes ...	—	—	—	—	—
	37	54	32	22	31

There was a total of 5 premature babies born at home during 1970 compared with 9 during 1969, all survived.

PREMATURE BIRTHS

LIVE BIRTHS

Weight at Birth	Born in Hospital				Born at home or in a Nursing Home Nursed entirely at home or in a Nursing Home				Born at home or in a Nursing Home Transferred to Hospital on or before 28th day				At hospital or in a Nursing Home.	
	Total Births.	Within 24 hours of Birth.	In 1 day and under 7 days.	In 7 days and under 28 days.	Total Births.	Within 24 hours of Birth.	In 1 day and under 7 days.	In 7 days and under 28 days.	Total Births.	Within 24 hours of Birth.	In 1 day and under 7 days.	In 7 days and under 28 days.		In Hospital.
1. 2 lbs. 3 ozs. or less ...	6	3	1	—	—	—	—	—	1	—	—	—	3	(14)
2. Over 2 lbs. 3 ozs. up to and including 3 lbs 4 ozs.	20	8	2	—	—	—	—	—	—	—	—	—	5	—
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	31	3	2	—	—	—	—	—	1	—	—	—	13	—
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	42	1	—	—	—	—	—	—	—	—	—	—	5	—
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	120	1	—	3	3	—	—	—	—	—	—	—	4	1
6. Total ...	219	16	5	3	3	—	—	—	2	—	—	—	30	1

Health Visiting

Recruitment has remained a difficulty this year although two students returned and are now engaged in full time health visiting practice. However, five health visitor scholarships were awarded this year and it is hoped that 1971 will see a full establishment of these valuable members of the health care teams

Number Scholarships awarded

1966	1967	1968	1969	1970
3	4	1	3	5

The continuing health care of all children and the counselling of parents, especially in the younger age group is a never-ending need, the health visitor remaining the primary worker in this field referring when necessary to her medical and social work colleagues.

Health care and health education are needed for all groups. Thirty-three age/sex registers have increasingly been available for the practice populations and assessment visits are continuing with the older age groups. Screening has also been carried out for cancer of the cervix for women over 35 years in 26 practices, in local authority clinics and in factory premises with the co-operation of our occupational health nurse colleagues.

Health visitors are holding sessions for obese patients in seven practices. They are also involved in follow-up visits to tuberculous patients and patients with various infectious diseases.

Table of Visits for 1970

					New Cases	Visits
Babies born in 1970	...	...	...	...	3,249	13,693
Babies born in 1969	...	...	...	...	3,360	12,633
Babies born in the years 1965-1968	...	...	...	...	5,840	14,273
Persons aged 65 and over	...	...	...	...	4,079	18,146
Mentally disordered persons	...	...	...	...	177	810
Persons discharged from hospital	...	...	...	...	131	—
Other cases	...	...	...	...	3,025	7,181
On account of tuberculosis	...	...	...	...	112	325
On account of other infectious diseases	...	...	...	...	397	375
Totals					20,370	67,436

Total Number of Visits

	1967	1968	1969	1970
Visits to babies and children under 5 years	53,058	49,801	44,836	40,599
Visits to other age groups	2,670	4,148	5,829	7,181
Visits to patients over 65 years	14,519	17,001	17,925	18,146
Visits to patients with mental disease ...	550	784	885	810

These figures show a decrease of visits to the under five age group compared to the previous three years; this is due to a reduction in the birth rate and the selection of visits with a further concentration of care on the 'at risk' children and their families, rather than routine visits to all. There are steady increases in visits to the over 65 and 'other' age groups over the last five years showing the greater involvement of health visiting care and support in the total general practice population. The total work pattern has however increased and the health visitor, like her district nurse colleague, is also becoming much more involved in sessions of work held at the surgery—working alongside the general practitioners.

Number of cervical smears taken by health visitors at G.P. surgeries	1,174
Number of vaccinations and immunisations given at G.P. surgeries	6,553
Number of patients seen for other reasons at G.P. surgeries (health and social advice etc.) ...	5,228
Number of child welfare sessions held with G.P. in surgeries ...	854

Apart from this wide variety of work the health visitors have also been involved in more formal health education sessions which are discussed in the special section later in this report.

Health visitors in the Whitehaven area attend the maternity unit weekly to meet the nursing staff and mothers to discuss problems of care. There were also follow-up visits to the hospital and in particular the paediatric departments in Carlisle and Whitehaven. Staff have been encouraged to liaise with nursing and social work staff in the hospital service in an effort to obtain a better continuity of care for the patient and the family.

Nursing Officers in the three areas continue to attend the ward rounds and case conference of the consultant geriatricians.

Training:

At a Group Advisers' Study Day in October, a lecture on Modern Health Visitor Training was given by Miss Smith, Head of Department of Nursing and Welfare Studies, at Newcastle-upon-Tyne polytechnic. This has proved most helpful to the health visitors involved in the training of students, as over the past few years there have been considerable changes in the training pattern.

In addition to providing field work experience for our own students, rural experience has also been provided during the year for 11 students from Bolton, Manchester and Newcastle-upon-Tyne health visitor training courses. Health visitors have also been involved in teaching general nurse students and student midwives.

The Nursing Officers have been involved during 1970 in teaching sessions to a variety of students — including district nurses, midwifery and general nurses.

Management courses at the two Technical Colleges have also requested lectures on the pattern of community nursing and the nurse management involved in this service.

Health Education

Health Education continues to be a larger part of the health visitors' work, both in her individual health teaching in home, surgery and clinic, and in group teaching situations. In order to help the health visitor and other nursing and medical staff in this work a review of all health education equipment and materials was carried out during 1970, and a "Health Education Handbook" produced, showing the location of available equipment and containing suggestions as to films and other visual aids which can be obtained. In the past, health education material was scattered all over the county; with the new system it is clearly easier for staff to know what is available and where it is to be located.

However, Health Education hardware is extremely expensive and it has not been possible, with the limited budget, to completely update all the equipment. It has been possible to purchase a large

Marler Hayley display stand which has been used for mounting displays and exhibitions using appropriate health education material, notably at staff lectures.

Also during 1970 two study days were held in the Art of Public Speaking. These were well attended by medical and health visiting staff and were found to be extremely useful. All staff at the course had an opportunity of giving a short talk and then having their talk discussed and constructively criticised by the lecturer.

Previously most health education has been aimed at mothers and children or at the elderly. The theme of a Conference held in London by the Health Education Council and attended by two of my nursing officers was "The Middle Aged Man", and it is becoming increasingly obvious that much of our health teaching must now be directed towards those in the middle years. Prevention of "stress" diseases should be our aim, and I feel that we must renew our efforts to educate the public about such topics as the dangers of smoking and thus help to prevent coronary artery disease, chronic bronchitis and lung cancer.

Now that nursing staff are attached to groups of general practitioners they are more likely than ever before to come into contact with the many "at risk" people in the middle age group. At a Health Visitors' Study Day in October, a session was devoted to those of middle years and to discussing health education for this group and an attempt made to obtain a better understanding of their particular needs.

It is encouraging that the number of health education sessions given on surgery premises is increasing, although this is to a large extent dependent on the suitability of premises available. Obesity clinics continue to be available in seven practices.

Antenatal classes in psychoprophylaxis or relaxation are available throughout the county. During 1970 special training was given to midwives and health visitors to enable those who had not previously done so to run these classes. This training will be continued in 1971.

It should be noted that a substantial amount of health education work of the department is carried out in connection with the School Health Service and an account of this is given in my Annual Report on that service.

Total sessions during 1970 were as follows:—

Schools	...	...	...	...	169
Clinics	...	...	...	...	70
Antenatal classes	...	...	...	...	364
Mothers' Clubs	...	...	...	...	19
Other Organisations	...	...	...	...	29
Surgeries	...	...	...	...	39
					<hr/>
Total sessions:					690
Total attendances:					9,535

HOME HELP SERVICE

Section 29 of the National Health Service Act, 1946

“A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, aged, or a child not over compulsory school age, within the meaning of the Education Act, 1944”.

HOME HELP SERVICE

The administration of the Home Help Service is due to change in April 1971, when the Service becomes the responsibility of the Social Services Department. This, therefore, is the last full year for which I shall make a report on the Home Help Service.

I would like through the medium of this report to thank all those members of staff who have contributed towards the smooth running and efficiency of this Service during the past 25 years. The home helps themselves, who have provided an excellent service, and the nursing officers and other nursing staff whose duties have been concerned with organisation.

As in previous years, the Service has been well used and much appreciated by the 1,595 recipients of assistance. The over 65 years of age group still form the largest proportion of people helped (84%) with a very small percentage (2%) of maternity cases.

During 1970 pilot schemes in Extended Community Care were run in each of the administrative areas. A main purpose of the proposed scheme was to provide a 24-hour service for patients not fit to be on their own. It was envisaged that this service would be used for patients waiting for hospital accommodation. The cost of such schemes is very high, however, and can only be provided on a very limited basis for carefully selected, usually short-term cases.

Study half-days have been arranged for home helps in each area and have been well attended. The main subject covered has been that of Nutrition in the Elderly. Often it is the home help who is first to realise that the elderly person whom she is visiting is living on a poorly balanced diet. Her visits to the home are of necessity much less formal than those of members of the family health care team. Her visits are also of longer duration and are more frequent, and through the domestic relationship which is built up it is easier for her simply in the course of her duties to observe her client's needs. She has a definite role to play and provides "an early warning system" of any change in an elderly person's

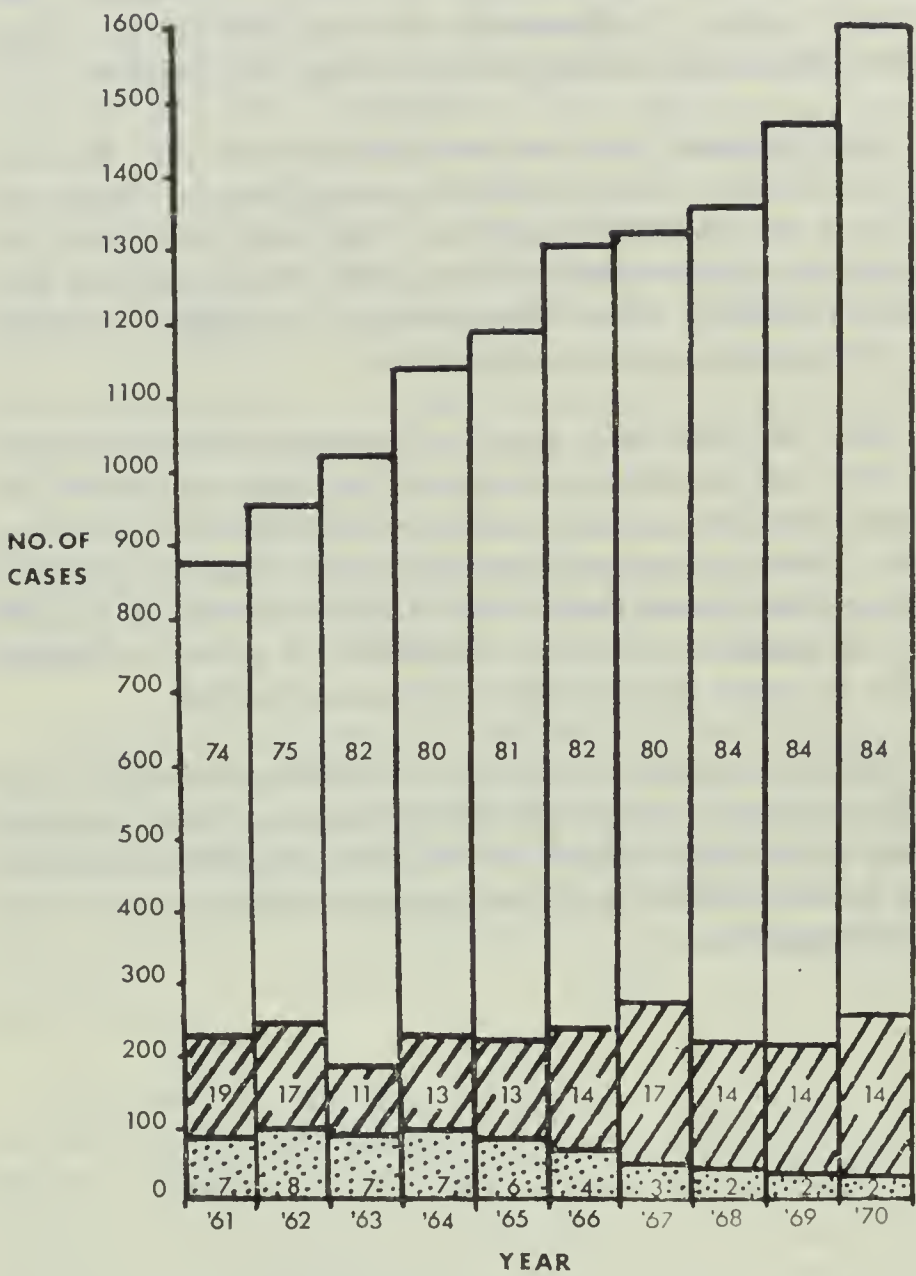
condition, and will report this to the family health care team. They, in turn, will call on such services as "Meals on Wheels" and Luncheon Clubs. The home help often uses her own knowledge to give some simple teaching in food values and nutrition.

This Authority has an arrangement with the Women's Institutes whereby welfare secretaries are appointed in villages and they draw the Authority's attention to the need for services and any change in circumstances. They advise on the type and scale of service required rather than indirectly providing the service. This often relates to home help work.

Some difficulties have arisen in cases where the introduction of a home help was felt to be essential, but where the recipient did not agree that help was needed and therefore did not agree to pay for it. However, such help may well be a means of keeping a patient at home rather than in an Old People's Home, or hospital, and it is therefore considered worthwhile to go to considerable trouble to ensure that the help is given and received.

The visits made by home helps are often greatly looked forward to by older people, especially those living alone. Someone coming in with news of local interest, some cheerful conversation and a friendly manner, is of great importance and has some degree of therapeutic value.

HOME HELP CASES — BY PERCENTAGE OF TOTAL



ELDERLY



OTHER ILLNESSES



MATERNITY

CARE OF MOTHERS AND YOUNG CHILDREN

Section 22 of the National Health Service Act, 1946

“It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority.”

CARE OF MOTHERS AND YOUNG CHILDREN

This area of work of the Health Department is one which is about to be considerably affected by the establishment of the Department of Social Services. Certain responsibilities under this heading will become those of the Director of Social Services as from 1st April, 1971, notably those concerned with the registration and supervision of playgroups for pre-school children as well as the home help service, which in the background has always played an important part in the care of certain families. Then again the local authority's part in the assistance of the unsupported mother and her child, including co-operation with the Diocesan Moral Welfare Association, also becomes a responsibility of the Director of Social Services.

Clearly for the future any risk of fragmentation of care for the family as a whole must be avoided and I am confident that this can be achieved. The Health Department and the Social Services Department of the County Council become partners in this important field of activity.

CARE OF THE UNMARRIED MOTHER AND HER CHILD

Under Section 22 of the 1946 National Health Service Act, local health authorities may with the approval of the Minister contribute to any voluntary organisation in making arrangements for the care of expectant and nursing mothers. With regard to the unsupported mother, the County Council in their proposals under Section 22 agreed to keep in close touch with the Diocesan Associations for social and moral welfare and unmarried mothers are looked after in Carlisle at Coledale Hall to the maintenance of which the County Council contributes. Since taking up her duties in 1967, Miss Wilson who is the Superintendent of Coledale Hall, has excellently carried out work which has been both difficult and demanding and made it possible for the Home to remain open for those mothers in need.

The point has probably now been reached when there should be consideration whether the local authorities should assume a

greater responsibility for what has hitherto been predominantly the work of religious organisations. The Seebohm Report says:—
“We recognise the outstanding pioneering work which has been done by voluntary bodies in this field, particularly religious organisations, and there is no suggestion that they be superseded. But we do recommend that first there should be a realistic alternative source of assistance to those unmarried mothers who do not wish to approach religious bodies, and second, that there should be a clear assignment of responsibility to the social service departments for ensuring adequate social care and advice for both the unmarried mother and her child.”

A reduction in the numbers of mothers using Mother and Baby Homes seems to reflect not only the national trend towards a decline in demand for the type of provision offered at these Homes, but of the changing pattern towards a more permissive attitude in society to illegitimacy. The Victorian attitude of rejection of the pregnant, unmarried girl from the family situation is disappearing.

The table below shows the illegitimacy rate for Cumberland and England and Wales for 1965-1970.

Administrative County		England and Wales
Rate per 100 total live births		Rate per 100 total live births
1965	5.6	7.7
1966	5.8	7.9
1967	6.6	8.4
1968	6.0	8.5
1969	6.6	8.4
1970	6.4	8.3

Over the past few years there has been a great increase in the number of babies who are kept by their unmarried mothers and not offered for adoption. In many cases this appears not a satis-

factory solution as it is extremely difficult to find suitable permanent accommodation. There is a growing need for flatlets under the care of a Warden. The provision of this form of accommodation would offer the security to the mothers necessary to enable them to bring up their children as normally as possible.

Mortality rates for illegitimate children are generally higher than for legitimate children, the unmarried mother often seeking antenatal care much later in her pregnancy and the standard of accommodation and diet is often inferior. I show below mortality rates for both Cumberland and England and Wales:—

Infant Death Rate

Year	Cumberland, England and Wales.		Cumberland, England and Wales.	
	Legitimate		Illegitimate.	
1965	16.5	18.5	22.6	24.9
1966	21.1	18.5	18.6	24.5
1967	16.0	17.9	29.7	23.7
1968	18.5	17.8	29.0	23.4
1969	18.2	17.4	26.8	25.4
1970	18.4	17.5	14.5	25.9

The next table shows the number of unmarried mothers for whom the County Council accepted supporting financial responsibility in a Mother and Baby Home. The percentage in brackets after each total indicates the proportion of all illegitimate births in that year for which provision was made.

	1966	1967	1968	1969	1970
15 years	—	1	—	—	—
16 years	3	2	2	2	2
17 years	10	2	1	7	4
18 years	5	4	4	2	4
19—24 years	18	13	15	13	5
25—30 years	4	1	2	2	—
31 years and over	2	1	1	—	1
No age given	—	—	—	—	2
	42(19%)	24(10%)	25(12%)	26(13%)	18(9%)

It is the policy of the County Council not to accept financial responsibility for any unmarried mothers being admitted to Homes where the confinement does not take place in hospital. However, in general the percentage of unmarried mothers delivered in a hospital maternity unit is equal to the percentage of married mothers.

Welfare Foods

The sale of welfare foods was originally introduced in 1940. This measure, although national, was even more essential at the time to a county predominantly rural and where transport was severely restricted. With the help of the Women's Royal Voluntary Service, milk and vitamins have been distributed to nominated representatives in small communities throughout the county for the past 30 years during 16 years of which it has been the statutory duty of the local health authority on behalf of the Department of Health and Social Security.

However, sales which reached a peak towards the middle and end of the 1950's have been declining steadily. Other proprietary brands have become available, and with the help of salesmanship techniques employed, have become accepted as being more attractive than National Dried Milk. Incentives such as mother care books, toothbrushes etc., together with other free extras supplied with the various brands now on the market all help to enhance the image of the commodity. Also to some extent choice can be influenced by the recommendations of professional people in maternity work, and lastly, welfare foods are no longer sold at child welfare clinics.

Since 1956 therefore the numbers of distribution points for welfare foods have steadily diminished. Issues became so small as to make the keeping of many points open unreasonable. Area Medical Officers are, however, still responsible for the distribution of welfare foods to some 70 points throughout the county.

The service given so willingly and efficiently by members of the Women's Royal Voluntary Service and other volunteers con-

tinues at its impressively high standard. I appreciate with gratitude the extreme difficulties which would be encountered in keeping the

welfare foods service operating in such a county without their help. Different county branches of the W.R.V.S. involve themselves in three areas of the county, cutting out unnecessary time spent in travelling from one side of the county to the other.

Year		National Milk	Dried (Tins)	Cod Liver Oil (Bottles)	Vitamin Tablets (Packets)	Orange Juice (Bottles)
1961	78,155	9,067	5,017	50,653
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,943
1964	74,886	4,909	2,235	36,389
1965	78,047	4,636	1,881	39,053
1966	74,902	4,326	1,771	41,636
1967	69,460	4,131	1,405	43,459
1968	67,116	3,844	1,138	42,705
1969	50,851	3,531	1,176	45,198
1970	47,359	3,230	1,198	48,635

It will be seen from the above figures that the number of bottles of orange juice sold in the year is increasing, but the reason for this is not clear.

REPORT ON THE DENTAL SERVICE FOR THE YEAR 1970

The dental service in Cumberland is now such that a fully comprehensive treatment programme can be offered and provided for all who desire to attend the County clinics.

Due to staff recruitment in 1970 there are now nine full time dental officers in post and one auxiliary — unfortunately one auxiliary left after only three months' service.

Now that more dental health education is being undertaken in the County, one sincerely hopes that three year old children will be brought into the clinics for examination and treatment, if it be required.

The future prospects of the children having sound, healthy and caries free mouths are better than ever before, because fluoridation has now started in approximately one third of Cumberland, and it is hoped that a further third will receive its benefits before the end of 1971.

Dental health education is also an important factor in the prevention of dental disease and, by the use of auxiliaries, it is hoped to hold talks in baby clinics so that young mothers may be taught the correct methods of oral hygiene and diet. It is surprising how few people know the correct method of tooth brushing. Also although knowing what foods should or should not be eaten many still have an incorrect diet mainly because comparatively few persons take the trouble to prepare fresh foods and would rather buy something which simply needs re-heating or serving as bought.

General anaesthesia has always been a major problem in Cumberland due to the large number of clinics which must of necessity, be provided to cover such a scattered population. In areas such as Whitehaven and Workington where there is a fair density of people, specialist anaesthetists are used for fortnightly anaesthetic sessions but this arrangement is not possible in the

other clinics because of the infrequency of this type of session. All other general anaesthetics are administered by two specially trained dental officers who carry portable equipment with them in order to avoid having expensive apparatus in all clinics which would be seldom used.

As far as is practicable one would like to see fewer, but larger, clinics so that dental officers, auxiliaries and all dental personnel could be together resulting in a more efficient service and better facilities for patients and operators. This would certainly mean more travelling for some people but, if better service can be given, this has to be given due weight. Centralisation could be an enormous advantage particularly as regards general anaesthetic sessions when consultant anaesthetists could advantageously be employed.

There is an enormous demand, and need, for orthodontic work and it is now possible to undertake all such work. In this work one is particularly grateful for the excellent liaison which one has with the consultant orthodontist in the hospital service because he is only too willing to see any or all of the county patients and advise and prescribe treatment for them or, if one so desires, take full control of the case. Integration and liaison with the hospitals cannot be stressed enough and one ultimately hopes for one united service.

In West Cumberland, thanks to the excellent help given by Dr. Ivan Davidson, Consultant Anaesthetist, all mentally and physically abnormal children receive full dental treatment, including fillings, under general anaesthesia at the hospital and this service is very much appreciated by both patients and parents. It is to be hoped that a similar service can be established in East Cumberland in the near future.

At one time it was customary to equate the number of fillings done with the number of extractions but there is little point in so doing now because for the past four years, including extractions for orthodontic purposes, approximately four teeth are filled for every tooth extracted. It is interesting, however, to note that in 1963 approximately only two and half teeth on average were filled for every one extracted.

These days much work is being taken out of our hands and done by computers but, so far, no dental material has been processed in Cumberland. In January, 1972, however, the computer will be used to extract the names and addresses of all three year old children and appointments will be sent to them for examination and treatment if the parents so wish.

FLUORIDATION OF WATER SUPPLIES

There is little change to report in the situation about the fluoridation of public water supplies.

About 62,000 people in the county have the benefit of water supplies which have had the fluoride content adjusted to the optimum level of one part per million. Almost all of them live in the Cocker-mouth/Maryport/Workington areas where the West Cumberland Water Board treat about three million gallons of potable water a day from the Crummock Water source. In addition, there is fluoridation in a small part of the county consisting of two parishes in the Border Rural District which get their water from the South Western Northumberland supply provided by the Newcastle and Gateshead Water Company.

Regular sampling has gone on in both these areas to ensure that the fluoride level has been maintained between the permissible limits.

There is agreement in principle with the West Cumberland Water Board to the fluoridation of its Quarry Hill and Hause Gill sources of supply but no starting dates have yet been settled.

Both the County Council and the South Cumberland Water Board have agreed to the fluoridation of the Ennerdale Lake source in the financial year 1971/72 and the necessary equipment is already on order. It is estimated that this source of supply serves a population of about 45,000, although this may be increased later by a re-organisation of the supplies to parts of the rural area around Whitehaven.

It is hoped that once the fluoridation of the Ennerdale supply is under way the Water Board will be able to consider similar benefits for the Millom area by treating the Baystone Bank supply.

The county area around Carlisle is served by the Carlisle Water Board and the population of around 30,000 mostly get their water from two sources. It is hoped that some time in 1972 these two supplies — Castle Carrock and Cumwhinton — will have their fluoride content adjusted to one part per million.

Thus, it is hoped that in 1972 about 60% of the population in the administrative county will have fluoridated water supplies. It may be a slow process raising this percentage as it involves a number of comparatively small schemes, some of which it may be uneconomical to deal with for some time to come. Their future so far as fluoridation is concerned may, in fact, rest more with the re-organisation of supplies than with the treatment of small schemes.

There is no further progress to report with the Eden Water Board, which has decided to take no action on fluoridation. The situation there is complicated by the fact that the Board serves two county authorities, Cumberland and Westmorland, and the latter has steadfastly held the opposite view to Cumberland County Council on this question.

To show, in years to come, that fluoridation has in fact brought great dental benefits, a survey has been undertaken by Professor P. Jackson, Professor of Children's and Preventive Dentistry at Leeds University. In addition, some information may be forthcoming from a scheme which is being considered at the present time to give dental appointments to all children when they attain the age of three years. It is hoped that the first of these appointments will be early in 1972 and very shortly after that we will be able to compare the findings of the dental officers on their first inspections of children who have had fluoridated water from birth with those in areas without this benefit

CHILD HEALTH CENTRES

The pattern of venue and the work carried out at child health centres is changing.

These sessions are held almost equally between local authority premises and general practitioner premises.

The numbers of children attending are also dividing out and this year sees a drop in attendances at local authority premises and a rise in general practitioner sessions. It is, however, gratifying to see a greater proportion of children attending and the drop in total attendances shows a more rational use by the mothers of these sessions.

A pruning of sessions during the year was felt to be essential so that the precious time of medical and nursing manpower could be used to the full, and in October a survey was carried out in the local authority centres to try and ascertain the medical and health visiting content of these sessions.

As the total immunising programmes goes over to the general practitioners, I see these child health sessions of the local authority being taken over more and more by doctors specially trained to carry out screening in developmental progress and the more general work of child care, with health teaching and advice being carried out by the general practitioner and health visitor in the general practitioner's setting which gives a continuity of care and advice to the mother.

I show on Page 80 the 1970 statistics for this service and quote below the forward look taken by Dr. J. E. Ainsworth, Medical Officer in Senior Post, Western Area who is spear-heading the development of clinics for the more specialised developmental assessment of young children, based on local authority centres, although no doubt in the future also based in group practice premises with the seconded assistance of a specially trained medical officer. Discussions will also be taking place during 1971 on the role of the health visitor in this more detailed developmental

screening which Dr. Ainsworth is basing on her latest training in London and Newcastle. She writes as follows:—

“In the pre-school child developmental screening examinations and assessments of difficult cases are being carried out in the Workington area, and through these specialised examinations early developmental delay can be recognised. If delay is recognised, it becomes possible by further examination to identify the underlying handicap or handicaps, and this includes social deprivation as this can cause developmental delay.

If children with handicaps are to be identified early, then *all* infants and children, some people believe, should have a series of periodic developmental screening examinations. When there is reason to suspect that a child has, in any way, delayed development, then this child is referred to an expert, such as the paediatrician, for further assessment and treatment, and for guidance of the parents.

Children with chronic handicaps, e.g. lungs, heart, metabolic or of cerebral origin, usually have multiple rather than single handicaps. Handicaps, and especially those of cerebral origin, lead to delay in development. These chronic handicaps are often present from early life, and secondary complications—medical, educational and social — frequently occur. These can be prevented only if comprehensive management of the child and its family are started early enough, hence early identification is therefore essential.

In planning these developmental screening examinations to pick up as early as possible children with delayed development, the child's function is considered in four main areas:—

1. Locomotion and Posture.
2. Vision and Fine Manipulation.
3. Hearing, Language and Speech Development
4. Everyday Skills and Social Development (including emotional relationships).

These screening examinations are carried out at special key ages because certain levels of development are known to be recognisable around these ages. These key ages are:—

6 weeks; 6 months; 10-12 months; 18 months;
2 years; 3 years; and 4 years.

In the Workington area we are carrying out these developmental examinations in the Child Health Centres, previously known as Child Welfare Clinics, and mothers are encouraged to bring their pre-school children by appointment for their special developmental screening examinations. By introducing an appointment system it has given time to each child for this examination to be adequately carried out. At Salterbeck Centre I have recently started extra developmental clinics by appointment, having six additional sessions each month to try to screen as many children as possible. The majority are screened only at 6 weeks, 6 months, 10-12 months 2 years, 3 years and 4 years, and are only seen otherwise if there is any concern or query.

I would hope or suggest, and would like to see, that as the future develops in a reconstructed National Health Service, it would be of much value to be able to develop an attachment to a group of family doctors to help to developmentally screen their pre-school children. This would be a move forward to the early discovery of handicaps and also greater co-operation would develop with the family doctor. This principle of attachment of nursing staff, i.e. district nurses, domiciliary midwives and health visitors, to groups of family doctors is already of value and well established and this could be a further useful extension of this. This, of course, would need a full understanding and appreciation of the role each has to play in relation to his or her particular interest and experience and would need true professional co-operation. In this way it should be possible for the Health Service to develop along the lines suggested in the second 'Green Paper' so that full use could be made of the limited resources of medical manpower available in this country, and at the same time providing the best possible service."

ATTENDANCES AT LOCAL AUTHORITY CHILD HEALTH CENTRES 1967 - 1970

No. of children attending
during the year and who
were aged.

Year.		No. of centres provided at end of year.	No. of child welfare sessions held per month at centre.	Under 1 year.	1 — 2 years.	2 — 5 years.	Total no. of children who attended during year.	Total attendances during year.
1967	...	33	117	2080	1859	1890	5829	32420
1968	...	32	131	3086	1450	1728	6264	31326
1969	...	29	134	1927	1812	1697	5436	31018
1970	...	27	90	2287	2794	2438	7529	20720
		Total number of sessions		...	...	...	459	
		Average attendance at each session						18

The number of children attending at well baby sessions in group practice centres was 11,048 involving 21 separate practices and 865 sessions.

CHILD HEALTH CENTRES, 1970

The following table gives particulars of the sessions and attendances at Child Health Centres throughout the County:—

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Northern Area					
Alston	Cottage Hospital, Alston	Wednesday	49	540	11
Anthorn	W.V.S. Welfare Office, Anthorn	2nd and 4th Thursday	—	—	—
Aspatria	North Road, Aspatria	Wednesday	48	759	16
Brampton	Union Lane, Brampton	Friday	51	1408	28
Dalston	Village Hall, Dalston	1st and 3rd Monday	23	317	14
Houghton	Village Hall, Houghton	2nd and 4th Wednesday	24	293	12
Hunsonby	The Institute, Hunsonby	1st and 3rd Thursday	15	267	17
Longtown	Burn Street, Longtown	Tuesday	44	818	18
Nenthead	Doctor's Surgery	1st Tuesday	12	61	5
Penrith	Brunswick Square, Penrith	Tuesday	46	1497	33
Scotby	Village Hall, Scotby	1st and 3rd Thursday	22	279	13
Thursby	Church Hall, Thursby	2nd and 4th Monday	22	213	9
Wetheral	Village Hall, Wetheral	2nd and 4th Thursday	23	290	13
Wigton	Birdcage Walk, Wigton	Monday	48	1080	22
			427	7,822	18

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Western Area					
Broughton	Nurse's House	3rd Wednesday	22	155	7
Cockermouth	Harford House, Cockermouth	Monday	48	774	16
Dearham	Nurse's Hse, Central Rd., Dearham	4th Wednesday	4	9	2
Keswick	13—15 Bank Street, Keswick	Thursday	50	565	11
Maryport	24 Selby Terrace, Maryport	2nd and 4th Tuesday	68	2689	39
Seaton	Miners' Welfare Hall, Seaton	2nd and 4th Thursday	27	522	19
WORKINGTON—					
Park Lane	Park Lane, Workington	Weds. & alternate Thursdays	103	2004	13
Salterbeck	Holden Rd., Salterbeck, Workington	Friday	49	578	12
			371	7,296	20
Southern Area					
Cleator Moor	Ennerdale Rd., Cleator Moor	Thursday	—	—	—
Egremont	St. Bridget's Lane, Egremont	Tuesday and Thursday	51	692	14
Millom	18, St. George's Rd., Millom	Tuesday	46	836	18
Seascale	Gosforth Road, Seascale	Thursday	52	986	18
Thornhill	Community Centre, Thornhill	1st and 3rd Wednesday	—	—	—
WHITEHAVEN—					
Flatt Walks	Flatt Walks, Whitehaven	Monday and Tuesday	50	1038	21
Mirehouse	Dent Rd., Mirehouse, Whitehaven	Monday	49	1072	22
Woodhouse	Woodhouse, Whitehaven	Wednesday	52	978	19
			300	5,602	18
			1,098	20,720	18
		GRAND TOTALS			

FAMILY PLANNING

Although the County Council agreed in principle in 1967 to provide a family planning service through the agency of the Family Planning Association, financial restrictions prevented the development until 1970. I am pleased to say that the authority has, however, now implemented its decision by giving direct grant aid to the Lakeland Branch of the Family Planning Association, in addition to making premises available as has been done for many years.

In accordance with the Family Planning Association's national family planning agency scheme there was, however, no place for the authority which wished to give a direct grant and, after meetings with officers of the Association, it was agreed that the Family Planning Association should provide an agency service in accordance with scheme 6, i.e. free consultation, treatment and supplies for medical cases only. It is likely to cost the authority considerably less than it had been prepared to give to the Family Planning Association as a direct grant.

Regular clinics are held at Alston, Keswick, Millom, Penrith, Whitehaven, Workington and Carlisle. At all except Carlisle the premises and equipment are provided by the authority, while in Carlisle the clinic is in premises made available by the Borough Council, although county patients living in the surrounding area are able to attend.

There have been a number of meetings between officers of the authority and officers of the Family Planning Association and the hospitals to discuss the future of family planning in the county. A move towards the provision of a directly run service by the local authority was considered but, in view of the impending re-organisation of the health services, it was felt that this should be deferred for the present, although it seems possible that a hospital based service with adequate provision for domiciliary cases, where this is felt necessary, could well be the plan for the future. The position of the general practitioner in family planning services must be looked at carefully and it is clear that further thought must be

given to this problem before any proposals can be put forward. Meanwhile, however, it has been agreed with the Family Planning Association that local authority nursing staff can make referrals to the Family Planning Association clinics in addition to doctors but it was also agreed that special documentation of these cases should be avoided so as to preclude the undesirable classification of some patients as "council cases".

The arrangements for family planning seem to be working satisfactorily throughout the county, although from time to time suggestions are received for the opening of additional clinics. Such requests have been passed on to the Family Planning Association but they are usually found, on investigation to be economically not viable and it seems that, as with so many other services in a rural area, they will have to be provided at selected strategically placed clinics.

I would like to thank the Family Planning Association for its splendid co-operation and especially for its forbearance in the period when financial assistance had been promised but was not forthcoming.

PRE-SCHOOL PLAYGROUPS

Under the Child Minders' Regulation Act 1948 as amended by the 1968 Act, Section 60 of the Health Services and Public Health Act, the local health authorities are obliged to keep registers of

- (a) premises in their area, other than premises wholly or mainly used as private dwellings where children are received to be looked after for the day or for a part or parts thereof of a duration or an aggregate duration of two hours or longer, or for any longer period not exceeding six days;
- (b) of persons in their area who for reward receive into their homes children, under the age of five to be looked after

for the day or for a part of parts thereof of a duration or an aggregate duration of two hours or longer or for any longer period not exceeding six days.

In the case of (a) the registration is of the premises as a nursery, and in (b) the registration is of the person responsible for a group as a child minder.

The popularity of playgroups is growing. In the northern area there has been a slight increase in the number of these groups, two of which changed their venue and there were three new nurseries and two child minder registrations during the year. (Since 1st January, 1971, a further four enquiries regarding the establishment of these groups have been received). It is the policy of this Department to encourage, and in special cases sponsor the attendance of those children in need, either because of conditions in their home environment, or because of some physical or mental handicap. In 1970 the County Council sponsored 8 such children. Orton Park continues to be actively used for play group purposes by members of the Carlisle and District Association for the Mentally Handicapped.

In the south, although there were a number of registration of premises during the year the position as at 31st December, 1970, was exactly the same as at the end of December 1969, i.e. 345 places available at nurseries and 22 places with child minders.

Four nurseries in the southern area have taken deprived or 'disadvantaged' children and during the year eight such children were accommodated. The sessional fee for five of these children was paid by the County Council and the remainder were allowed to attend free of charge.

In the western area, during the past year, one new nursery and two child minder groups were registered. The number of places available is 357.

During 1970 a Branch of the Pre-School Play Groups Association was established in Workington and in discussion with the Secretary it was apparent that there were many areas for fruitful co-operation with the Health Department in the supporting and encouraging of new pre-school play groups and in the education of the organisers for their important role. In her contribution on this subject below Dr Ainsworth comments on a contribution she made to this and I regard it as highly important that the development of these play groups should be closely associated with the local authority's services, medical, social and educational. Dr. Ainsworth comments on the need for extending provision for the pre-school child is a reflection of a national groundswell on this matter with the principal need undoubtedly lying with the socially disadvantaged child

I am indebted to Dr Ainsworth, Medical Officer in Senior Post, for the following report:—

“My work in child development in the Child Health Centres and extending into the Infants' Schools, and to problems that arise later at 8, 9 and 10 years of age in the Junior Schools, has greatly impressed upon me that there is a great need, in the Workington area, for a much greater provision of pre-school Nurseries, if possible free of charge under the auspices and organisation of the local authority. The mothers who have sparked off and made some effort to fulfill this need in this area I think have realised and offered a valuable service by their own efforts to start and run Nurseries and Play Groups. Those I have visited in Workington and Cockermouth have readily made every effort, after the reasons were explained to them, to abide by the requirements for the Registration of Nurseries and Child Minders. They have taken handicapped children, and it is very encouraging that they could understand the need for these children also to mix with, and gain from, association with children without handicaps. At Carlton Road Nursery, Mrs. Glaister has readily accommodated two spastic children for us — one is severely handicapped in her motor development but is a bright little child of average intelligence

with great interference with her speech and movement because of her spasticity. The other child is less severely handicapped physically, but was emotionally more immature and more dependent on her mother. Mrs. Glaister has contacted me to discuss any queries she has had with these handicapped children, and this is very valuable all round. Dr. Ellis, from the Percy Hedley Centre for Spastics, at Newcastle, praises the tolerance and acceptance there is in West Cumberland for the handicapped child, both in the pre-school groups and also in the Infants' Schools wherever possible.

Mrs. Knapper, of Westfield, contacted me in 1970 on behalf of the Pre-school Play Group Association and asked me to talk to their members in the West Cumberland Branch. I was very pleased to do this and try to help them as they are filling such a worthwhile need for pre-school children. The talk was about Normal Physical and Mental Development of the 3, 4 and 5 year old, and we discussed normal emotional development of the pre-school child so that they would have a basis for understanding further information. I then talked to them about certain deviations from normal and explained why some behaviour was still normal at certain ages. We had

questions and some discussion after the talk and they found this information of great value. They said it gave them a greater understanding of what is normal and what it not, in the age groups with which they work. Mrs. Knapper commented that it was even helpful to them as parents, as it helped them to understand more about their own pre-school children.

I feel that the information I made available to them during this talk could possibly be a means of some children who were delayed in development, or abnormal in behaviour, being guided tactfully for further advice. This could be a further means of helping to pick up and eventually give help to a pre-school child with some abnormality of emotional or other development.

The people who have started these play groups in this area in my view are only scratching the surface of what is needed. This realisation of the great need here has been impressed upon my mind repeatedly while I have been working in the Child Health Centre and during my visits to the schools. I see pre-school children who would benefit greatly from attending a nursery or play group, but mother feels she cannot afford to pay for the child to go, or does not realise the benefit her child would gain. I think this brings to the surface another need, that the mothers need education about the advantages of nursery school from three years onwards.

I can see, if this service is developed, the following advantages ensuing — which at present are only given to the more privileged pre-school children who are from homes where they are going to get stimulation in any case:—

1. Tired, overwrought mothers get some relief and this benefits their families.
2. A great contribution to the pre-school child's emotional and social development. The Health Visitors and Medical Officers in Child Health Centres could recommend, from those they see, children who would benefit by attending.
3. Children with handicaps — mental, physical and/or emotional — are those in special need and these would be greatly helped by contact with children without handicaps, and this would greatly help these children later in living within the community.
4. The sudden transition from home to Infant School can be very traumatic to a child, and I have seen children after starting Infant school take one or two terms to recover, and during this time the emotional distress affects their learning ability. Those who have attended a pre-school play group or a nursery make this transition quite easily. They are socially and emotionally prepared

by their attendance, and hence these children have an advantage straight away over those who have never attended, and if this is coupled with social and/or emotional deprivation of stimulation at home this can have an important effect on a child's educational attainments at school.

Also, I think that if this service was available, even the mothers who find it difficult to realise what an advantage pre-school nursery or play group activity is to their children, would eventually come to feel this was a good idea because 'what one parent does many others feel they should do' — with a resultant benefit to the children. This would also provide for these mothers a valuable contact with others, with opportunities for discussion and education as to how children can be helped.

Another facet here is that occasionally we have a child so severely damaged emotionally, e.g., by early deprivation by its mother, to be even functioning at school age as a 3 year old. We have one such child attending one of our Infant schools at present. If we had a Nursery department this child would be better placed at present with a pre-school group as this is all he is ready for, even although he is of school age. In suitable pre-school groups or classes, this sort of labile situation could probably be encompassed.

Pre-school Nurseries and Child Minders are to me all part of one's interest in the pre-school child and his development. Before five years it is vital, I feel, to give the child as full an opportunity to develop, because it is thought that 50% of a child's future is laid down before five years of age."

In the financial year 1970/71 a small sum was included in the Health and Welfare Department's estimates specifically for the support of pre-school play groups which were helping in the integration of children with special needs, either medical or social. Although the sum of £200 is a very small one it represented some-

thing of a break-through in this matter and proved very useful in providing a little help for certain groups. As in all other services, the all too familiar financial stringencies of the budget have hitherto precluded more ambitious direct help for pre-school activity and I know that the Director of Social Services, to whom the administration of these nurseries and play groups now passes, will be equally keen to do everything possible to promote their extension in the years ahead

One problem in the rural areas which is a substantial one, and which would require more ambitious sums of money, is that of transporting children distances to situations where play groups are run. It has not been possible to do much in this direction hitherto. Groups are, however, now granted the use of County Council premises wherever possible on very favourable terms.

Yet another example of the gathering enthusiasm for these groups has been the establishment of pre-school playgroup associations, one for the north at Brampton, one in Carlisle, and one in the west.

Mrs. P. C. Knapper, who is Chairman of the North Western Branch of the Pre-school Playgroups Association, has been kind enough to contribute the following account of the work of this Association.

Playgroups in Western Area and Southern Area

"There are about two dozen playgrounds in these two areas, not all of which belong to the West Cumberland Branch of the P.P.A. — about half of them have paid a subscription. The playgroups are run in different ways. Some are organised by volunteer helpers: some have a committee of mothers which pay qualified people to supervise the groups: some are organised by a few mothers who receive a small salary and are helped by a rota of volunteer mothers. The policy of the P.P.A. is to have as much mother involvement as possible for the mothers' benefit. Very few of the playgroups in these areas are members of the P.P.A. It is not necessary to belong to the organisation to belong to our branch.

The branch has notified every playgroup of its meetings, whether the playgroup has joined us or not. We will be unable to do so in future since it costs too much.

Most playgroups follow the pattern of dividing the session by a refreshment break and having free play (with climbing and wheeled apparatus; domestic corners, reading corners, table constructions, toys, larger constructional toys, painting, clay and dough and papercraft, dressing up material, sand and water) on one side of the break and more organised community activities (music and movement, rhymes and songs, story etc.) on the other. The prices charged by the play groups vary from 2s. 9d. to 6s. 0d.

The programme of the West Cumberland branch of the P.P.A. has included two courses organised by John Dent, the Tutor for Further Education, at Whitehaven. They were both taken by Miss Anne Morceton of Lancaster University, and Miss Muriel Bamber of the Charlotte Mason College. The first, held in the Spring of 1970, was on the 'Theory of Play and Development of the Child'. We also had several practical sessions with paper and paint. This autumn the course concentrated on music, drama and the story. Both courses were well attended (c. 40) and were whole-heartedly enjoyed by us all. They were most stimulating.

Other meetings of the branch have been addressed by Peter Lawson and Mrs. Young, the Schools' Librarian, and Dr. Ainsworth. There was also a practical handwork demonstration before Christmas. Mrs. Legerwood is to meet us next month when we have our Annual General Meeting, and Dr. Platt has promised to come in the future as has the Music Adviser for Primary Schools.

There has been little connection between the playgroups and the primary schools. At Westfield the supervisors spent a morning at Westfield Infants' School, and the Headmistress and reception class teacher came to playgroup one afternoon. Other playgroups may follow suit — not all school teachers

are very interested in the playgroup movement. The health visitors sometimes recommend that children be brought to playgroup, but very often their parents are not prepared to persevere if their child does not immediately settle down."

REGISTERED NURSERIES

<i>Northern Area</i>		<i>Southern Area</i>		<i>Western Area</i>	
Abbeytown	20	Bootle	15	Broughton	20
Alston	20	Cleator Moor	10	Cockermouth (3)	90
Aspatia	30	Distington	30	Crosby	23
Brampton	30	Egremont	30	Harrington	20
Orton Park,		Frizington	20	Keswick	40
Carlisle	12	Gosforth	10	Loweswater	12
Dalston	20	Millom	30	Portinscale	20
Heads Nook	25	Seascale (3)	70	Seaton	30
Houghton	30	St. Bees	20	Workington	90
Hunsonby	30	Whitehaven (3)	110		
Kirkbampton	20				
Kirkbride	10				
Longtown	25				
Penrith	35				
Scaleby	10				
Scotby	30				
Wigton	25				
	<hr/>		<hr/>		<hr/>
	382		345		345
	<hr/>		<hr/>		<hr/>

REGISTERED CHILD MINDERS

<i>Northern Area</i>		<i>Southern Area</i>		<i>Western Area</i>	
Brampton (2)	28	Egremont	1	Workington (3)	12
Culgaith	2	Millom (2)	2		
Penrith	15	Seascale	10		
		St. Bees	8		
		Whitehaven	1		
	<hr/>		<hr/>		<hr/>
	45		22		12
	<hr/>		<hr/>		<hr/>

MARRIAGE GUIDANCE COUNCILS

The purpose of a marriage guidance council is to offer remedial help to those with trouble and difficulties in their marriage. There are two such Councils in the county: the Cumberland and Eden Valley Marriage Guidance Council, and the Barrow and District Marriage Guidance Council. Assistance is given by the County Council to these two organisations in the form of an annual grant together with accommodation in Park Lane Clinic, Workington, and Brunswick Square Clinic, Penrith.

This year brought a reduction in the age of majority from 21 to 18 years and this is yet another reason for the importance and need for preventive work in the form of youth counselling. Greater emphasis is being placed on educational youth counselling, marriage guidance counsellors visiting schools to lecture and encourage discussion. Marriage guidance is also included in the nursing education programme with talks given to pupil midwives and lectures included in the district nurse training course.

In addition to this, two 1-day seminars were held last summer at West Cumberland College of Technology and Science, and at the Technical College in Carlisle. Teachers of secondary schools in the City and County of Cumberland were able to meet members of the National Marriage Guidance Council in company with local Marriage Guidance counsellors. A short residential course was also organised for secondary school teachers. This took place at Newton Rigg and the subject was counselling and personal relationships.

Although the Marriage Guidance service has established itself in the county as a social and highly valued service to the community, its activities have until recently been restricted to Carlisle and East Cumberland. This has been due in the main to the absence of a marriage guidance counsellor.

Recently the Government announced their programme of Urban Development, the purpose of which is to improve social services in areas of special social need by means of grant aid. I

am of the opinion that West Cumberland could benefit greatly by the extension of marriage guidance activities and to help the existing arrangements, application has been made to the Department of Health and Social Security on behalf of the Eden Valley Guidance Council for an annual grant of £250 to help in the maintenance of a Marriage Guidance Council branch recently established in West Cumberland.

The following table indicates the number of new cases dealt with annually since 1962. The Catholic Advisory Council is no longer practising as a Marriage Guidance Council.

CARLISLE, CUMBERLAND & EDEN VALLEY COUNCIL

Year	Carlisle	Workington	Penrith	West Cumb. & East Cumb. couples seen in Carlisle.	Catholic Advisory Council	Total
1962	57	—	—	—	—	57
1963	55	19	—	—	18	92
1964	15	36	—	—	15	66
1965	39	39	—	—	3	81
1966	42	17	—	—	2	61
1967	28	14	—	—	—	42
1968	40	15	3	16	—	74
1969	19	1	8	6	—	34
1970	39	—	4	32	—	75

It will be seen from the above figures that the Workington branch, which commenced in 1963, ceased to function in 1969, due to the absence of a marriage guidance counsellor. However, as a trained representative is once again practising in the Workington area, and the County Council have been able to provide accommodation in Park Lanc Clinic, I am pleased to say the service will again be available in West Cumberland during 1971.

I am indebted to Mrs J. Perry for her account of the activities of Barrow and District Marriage Guidance Council during the past year:—

"There have in fact been only two cases in the Millom area last year. Publicity material has been asked for owing to the fact that a number of couples have requested separate housing from the Millom Housing Department. Material for Marriage Guidance Council publicity in the area is being provided. We have advertised the services of the Marriage Guidance Council in the Millom News (a weekly paper) recently for two Friday evenings."

Mrs. M. D. Slee, Secretary of the Eden Valley Marriage Guidance Council, has also been kind enough to provide me with an account of the work done by the Council during the year.

"The work of the Council during 1970 centred at Carlisle and Penrith has followed a similar pattern to the previous year, and again we have had an increase in the number of cases dealt with. Seventy-five new cases were opened involving 142 children under the age of 16. Thirty-six of these were cases from the county, 22 from East Cumberland and 14 from West Cumberland. There were 217 interviews given, approximately half of these being from the county.

The Educational Counsellors have had a very full and busy year, 132 sessions being given to the Carlisle schools involving 722 pupils, and 120 sessions to the Cumberland schools involving 583 pupils. They have also held group sessions with the Guides, Scouts, Rangers and Young Farmers' Clubs.

Training sessions have been held with teachers in the City and County, and a course of discussions was given to the County Children's Officers by our Regional Officer, Mrs. Wendy Allen. We are now fortunate in having a trained Counsellor in West Cumberland who is currently counselling at Park Lane Clinic, Workington, and we are hoping that this service will become widely known."

VACCINATION AND IMMUNISATION

Section 26 of the National Health Service Act, 1946

“Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox and the immunisation of such persons against diphtheria”.

VACCINATION AND IMMUNISATION

Local health authorities are responsible under Section 26 of the National Health Service Act 1946 for making adequate arrangements for protection against diphtheria, whooping cough, tetanus and smallpox either by the Council's medical staff in schools and welfare clinics or by participation by general practitioners.

The most outstanding event in the field of vaccination and immunisation during the year was the completion for the whole of the county of the administration connected with the computer call up for all those children born on or after 1st January, 1969. Twice monthly the computer produces appointment cards for all children due for immunisation. Parallel to this, lists of those given appointments are sent to the practice concerned.

The computer is programmed to make appointments in accordance with the following schedule which is in line with the recommendations of the standing medical advisory committee of the Central Health Services Council and the Joint Committee on Vaccination and Immunisation.

6 months	Diph/Tet/Pert. and Oral Polio
8 months	Diph/Tet/Pert. and Oral Polio
14 months	Diph/Tet/Pert. and Oral Polio
15 months	Measles
16 months	Smallpox
4 years 6 months	Diph/Tet. and Oral Polio
4 years 7 months	Smallpox revaccination

This schedule enables a child to complete the programme of vaccination and immunisation before entering school.

This then is the culmination of the work done over the past few years by the nursing staff to encourage parents to take advantage of the available facilities for protection of children in early childhood.

Vaccination against measles was resumed in April after the withdrawal of vaccine by the Ministry in the previous year. Despite efforts of the staff of the Department, Press publicity and infiltration of the schools, it was only after intensive publicity at national level that it was possible to resume the programme effectively, eventually overcoming a certain amount of prejudice and lack of interest.

The earliest indications from the computer data bank are that of all children born in 1969, 85% are protected against measles. The final figure will be nearer 90% and it is said that almost 10% of parents have withdrawn their consent to this protection — consent originally given at the time of the child's birth. Parents should be in no doubt as to the effectiveness and safety of the measles vaccine now in use.

Diphtheria Immunisation:

The numbers of children immunised during the year were as follows:—

Primary Courses—pre-school children	...	2,035	(2,080)
Primary Courses—school children	...	353	(460)
Reinforcing injections—pre-school children	... ..	890	(1,705)
Reinforcing injections—school children	...	2,763	(3,760)

Tetanus Immunisation:

During 1970 the following numbers of children were immunised

Primary Courses—pre-school children	...	2,033	(2,877)
Primary Courses—school children	...	372	(507)
Reinforcing injections—pre-school children		902	(1,719)
Reinforcing injections—school children	...	3,863	(3,950)

Whooping Cough Immunisation:

The numbers of children immunised in 1970 were as follows:-

Primary Courses—pre-school children	...	2,028	(2,055)
Primary Courses—school children	...	24	(47)
Reinforcing injections—pre-school children		845	(1,624)
Reinforcing injections—school children	...	259	(358)

The reduction in the figures from 1969 for diphtheria, whooping cough and tetanus protection is accounted for by the fact that the current schedule of vaccinations and immunisations no longer provides for a reinforcement dose at 10 years of age. In fact the number of children whose protection was brought up to date (i.e. either reinforced or given primary protection after having most things in earlier life) at school entry stage has remained very constant over recent years at approximately 2,800. This results in about 80% of children at this stage being fully protected, a figure about which we should not be complacent in view of the ever pressing hazards of the return to diphtheria, as was illustrated recently in the Manchester and London areas.

Poliomyelitis Vaccination:

Primary Courses—pre-school age	... ..	2,268	(2,200)
Primary Courses—school children	...	401	(610)
Reinforcing injections—pre-school children		161	(182)
Reinforcing injections—school children	...	3,561	(2,947)

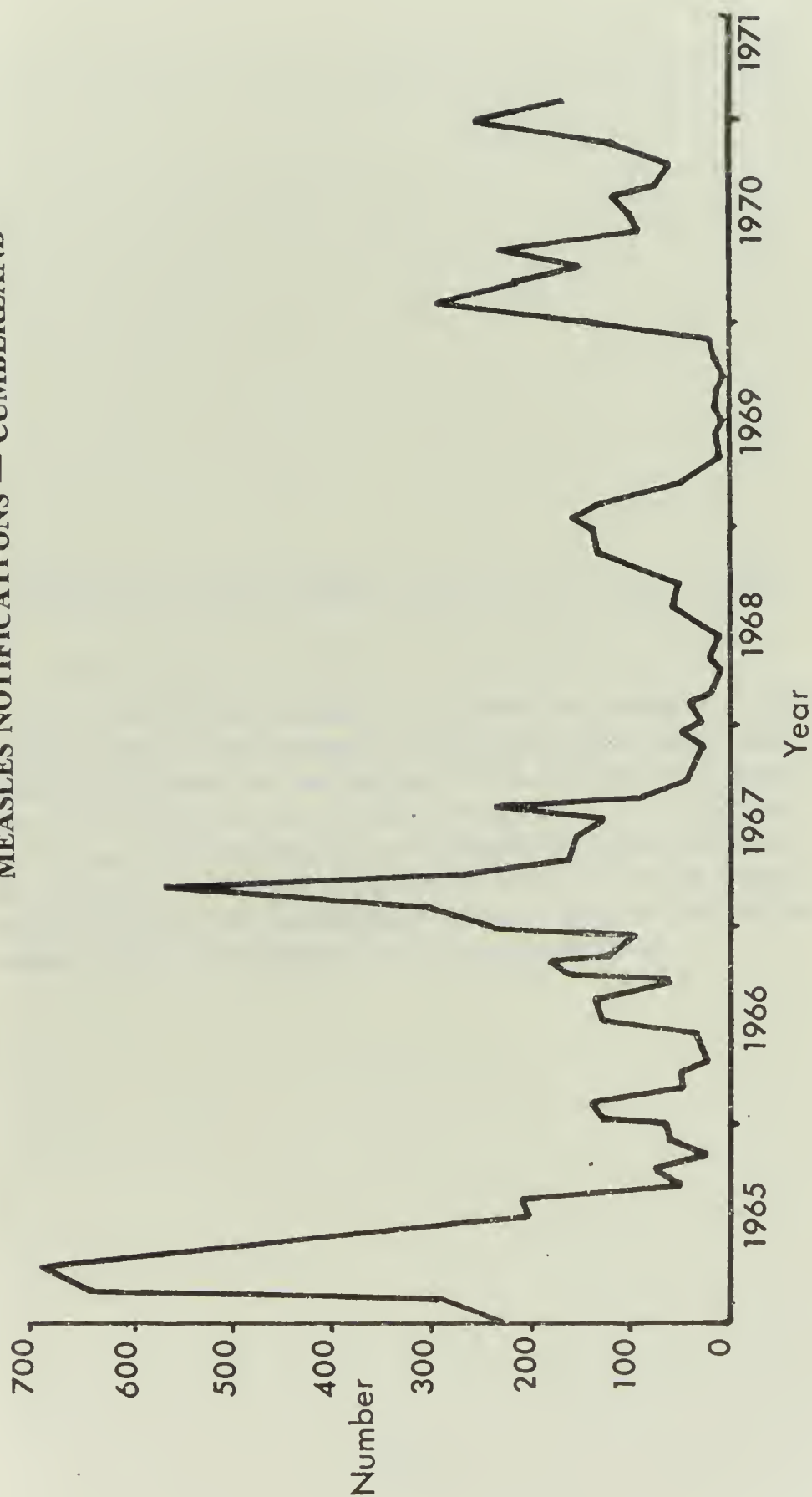
Smallpox Vaccination:

Number of pre-school children	... ..	1,079
Number of school children	... ..	95

The number of children vaccinated against tuberculosis by B.C.G. vaccination was 2,755.

During the latter part of 1970 a recommended vaccine against Rubella (German Measles) began to become available but very limited supplies were obtainable before the beginning of 1971. Plans were, however, laid for the protection of all thirteen year old girls at school early in 1971 and at the time of writing this report this exercise is nearing completion. Although it is not yet clear just how long this immunity will last it is anticipated that girls of this age will carry their protection well into their later child bearing years. Any need for reinforcement later will become apparent from on-going research and can be dealt with as required. In due course both older and younger girls will be able to receive rubella vaccine and ultimately it will find a place in the schedule operating through the computer scheme.

MEASLES NOTIFICATIONS — CUMBERLAND



PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946

“A local health authority, may, with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness, the care of such persons suffering from illness . . . , or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the managements.”

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

The various subjects touched upon in this section of my report reflect wide ranging contacts by the department within the community and with colleagues in other branches of the health service. The section on cervical cytology and on nursing equipment for loan involve a large number of the community nurses in their day to day work. Then the chiropody service is undoubtedly one of the most deeply appreciated by the predominantly elderly population who receive its benefits. While Cumberland is, to some extent, mercifully isolated from a national and international growing menace of venereal disease, Dr. Bell's report makes rather sombre reading. So also do those of the consultant chest physicians, to whom I am once again greatly indebted for their reports on East and West Cumberland respectively. The latter are published in full as appendices to this report and, while there has fortunately not been a great increase in lung cancer seen locally during 1970, the national picture shows a frightening relentlessness in the death toll from this disease. The further report of the Royal College of Physicians recently published underlines this whole problem very sombrely.

CERVICAL CYTOLOGY

The screening of women for the early detection of cancer of the cervix had been going on in a limited way, mainly through hospital post-natal and gynaecological clinics and through family planning association clinics before 1965. It was in this year, however, that there was an upsurge of public interest which led to local authorities inaugurating schemes whereby a more widespread effort could be made to women in the community between the ages of 30 and 50 to come forward for cervical smear testing. In the year 1965 1,663 women were so screened at local authority clinics in Cumberland, while the following year 1966 proved a peak period in which over 4,000 women came forward to these clinics. Thereafter the numbers screened in the clinics settled to an average of approximately 1,500 per year. At the same time, of course, larger numbers began to be screened through hospital clinics and the

numbers of smears taken at family planning clinics also rose. Repeated efforts were made in the matter of the publicity of this effort and it was always recognised that many of the mothers at greatest risk of cancer of the cervix, i.e. mainly those in the lower socio-economic groups, were those least likely to come forward on their own initiative. The community nursing staff put a lot of work into encouraging women in these groups to come forward for cervical cytology.

In common, however, with many other activities which had hitherto been mainly centred on local authority clinics this screening exercise on cervical cytology has in Cumberland progressively moved towards the group practice centre and has become an important preventive health activity of the family health team in its care of the well as well as the sick in the community. The concept of the well women's clinic on a practice basis has taken shape and some measure of this is given by the fact that in 1970 a total of 3,832 cervical smears were taken by the county nursing staff, a figure which includes approximately 1,400 taken in clinics. Thus just over 2,400 smears were taken by nurses as part of family health care team activities in group practice centres. This movement has been greatly facilitated by the co-operation of the Clerk to the Executive Council in providing age/sex registers. These are widely used now in the practices for the issue of direct invitations to women to attend for cervical cytology.

All of this has entailed a colossal job for the pathology departments both at the Cumberland Infirmary and at the West Cumberland Hospital. Part of this has been the documentation of the work and the revision of the statistics thereon. In 1970 the hospital laboratories examined a grand total of 13,221 cervical smears, approximately half of these originating in hospital clinics and a further 4,000 coming from general practitioner premises. These total figures refer, of course, to the whole area served by the Special Area Committee and not only to the administrative county of Cumberland.

The hospital laboratories have recorded a total of 446 positive smears over the years in which the screening procedure has been

carried out. This must represent, after full clinical investigation, a substantial number of women in whose case the disease has been detected at a very early stage.

Five Year Recall

In the absence of a national recall scheme a local scheme was evolved with the consultant pathologist in the East Cumberland Hospital Group to recall for a further test those women who had initially been tested when the local authority scheme was introduced in 1965. This was a tremendous task for the staff of the pathology laboratory at the Cumberland Infirmary as they were already preparing lists for the recall of women who had been screened at gynaecology and family planning clinics in the years 1962 to 1964. The task was so great that in order to commence the preparation of lists for those initially tested in 1965 the list for 1964 was abandoned and in fact only lists for those women originally tested during 1962/63 and January to July, 1965, were dealt with this year.

It is very interesting to note that of 3,500 women screened during a particular period of 1965 and considered for 5 year recall in 1970 just over 1,600 were eliminated for various reasons. The main one of which was that they had in the interval, in fact, had a further smear taken. 1,250 names were finally submitted for recall and ultimately the number of follow-up smears received was just over 250. Thus a very small proportion of women apparently qualifying for a five year recall were finally re-screened on this basis.

I believe, however, that there is a case for considering the use of a computer for the recall of women for repeated smear and I will be exploring this possibility with my colleagues during the course of 1971.

NURSING EQUIPMENT ON SHORT TERM LOAN

Local health authorities are empowered, under Section 28 of the National Health Service Act, 1946, to issue, free and on temporary loan, equipment needed for the care and aftercare of patients in their own homes.

The home nurses have supplies of smaller items of equipment such as bedpans, plastic sheeting, incontinence pads, etc., but the larger items such as invalid chairs, commodes, walking aids and mattresses, are issued through the British Red Cross Society who act as agents for the authority. The British Red Cross Society get an annual grant towards the cost of running the depots which they have at Carlisle, Workington and Whitehaven, manned by volunteers from the Society.

The equipment which is loaned through the British Red Cross Society is intended to be of a temporary nature and patients who are hospital in-patients or out-patients and are considered to need permanently such items as invalid chairs and walking aids obtain them from the Ministry of Health and Social Security on the certification of a hospital consultant. It is essential that a measure of flexibility exists between the local authority and the hospitals in this matter and, from time to time, meetings are arranged with officers of the Hospital Management Committees to smooth out any difficulties which have arisen. One of the arrangements made at these meetings is that the local authority will loan equipment to patients who are awaiting delivery of permanent items from the Department of Health and Social Security.

The following table indicates the type and amount of nursing equipment which has been loaned in 1970:—

Equipment			1966	1967	1968	1969	1970
Commodes	...	...	141	129	123	100	116
Crutches	...	...	31	31	67	48	34
Hoists, hydraulic	...	...	—	3	9	4	13
Hospital Beds	...	...	12	7	21	12	12
Lifters (Penryn)	...	...	—	—	—	—	6
Invalid Chairs:							
Adult type	...	...	167	127	129	76	74
Junior type	...	...	5	9	13	4	3
Car	...	...	—	—	—	—	36
Mattresses							
Rubber	...	...	14	8	23	11	7
Inflatable	...	...	3	—	1	—	—
Hair	...	...	—	—	1	—	—
Walking Aids	...	...	159	153	95	201	198

It will be seen that the use of hoists for lifting heavy patients and Penryn lifters are on the increase. These are expensive pieces of equipment and the problem at present is estimating just what stock should be carried.

The demand for ripple beds is becoming a regular feature of the loan equipment scheme. They have proved invaluable in the care and treatment of patients with pressure sores and are now an accepted part of the service. They are not bought outright by the County Council but are hired as needed. There were 19 occasions on which these beds had to be hired during 1970.

Patients, or their relatives, are expected to return equipment as soon as the need for it ceases but recovery of the equipment is, in fact, one of the administrative difficulties of the scheme, and it has been found that a routine annual check of all equipment on loan to ensure that it is still necessary is essential.

The loan equipment service is complimentary to, and an invaluable ally to, a highly developed community nursing service and I think that in this county much of the success of the scheme is due to the efforts of the volunteers of the British Red Cross Society.

DOMICILIARY PHYSIOTHERAPY

This service continues on a limited basis through services in two parts of the county of part time physiotherapists. I know that other groups of doctors would welcome similar services in their practices but trained physiotherapists are rare and very naturally the greater part of the services available in this speciality are absorbed by the hospitals. The joint scholarship arrangements with West Cumberland Hospital and the County Council received a little bit of a set-back in the withdrawal of the holder of the current scholarship from her training course but it is hoped that another young lady in training may take the scholarship up and so sustain this beginning of the more regular flow of trained personnel to the county.

CONVALESCENCE

The number of people admitted to a home for convalescent care during 1970 was thirty-five, a continuation of the gradual decrease in the use of the service. The following table shows how this steady fall has gone on since 1965, although it must be borne in mind that it is now clear that prior to 1967 there was a tendency for general practitioners to use the convalescent homes as a means of providing holidays for the chronic sick or for elderly patients who had to be cared for to enable relatives to take a holiday.

No. of Admissions

1965	144
1966	99
1967	49
1968	55
1969	39
1970	35

A few years ago patients were being recommended for admission to specific convalescent homes, many of which were outside the county, but for the past two years all admissions have been to the Silloth Convalescent Home. It is interesting to note that the need for convalescence apparently varies from area to area, as there were sixteen admissions from the northern area, fifteen from the western area and only four from the southern area.

Silloth Convalescent Home, which is situated on the Solway coast (in fact almost on the beach) enjoys climatic conditions which are generally mild and agreeable to most cases. It is of reasonably easy access at any time of the year, and enjoys an excellent reputation for care, comfort and consideration. It is registered as a nursing home under the Nursing Homes Act, 1963, and is run on a non-profit basis under the guidance of an active Management Committee, of which I am a member. The home is excellently staffed by matron, nurses and ancillary staff and is used by the Hospital Board, a substantial number of patients coming from outside Cumberland.

CHIROPODY SERVICE

The chiropody service which is provided for the elderly, the physically handicapped and expectant mothers has continued to expand. After a rapid rate of growth in the early years after the service was established in 1960 it settled to a fairly steady expansion of 5% per year, but in 1969 this fell to only 1%. There was some conjecture as to whether this indicated that a plateau in referrals had been reached but as the growth in 1970 was 3% it seems that it was more probably associated with staffing difficulties. Certainly, the staffing situation has been better in 1970 than at any time for many years and what is especially pleasing to report is that while the number of patients increased by 3% during the year (from 6,300 to 6,503) the number of treatments increased by 9% (from 25,869 in 1969 to 28,203).

While the service is available for the elderly, the physically handicapped and expectant mothers, it is, for all practical purposes, catering for the needs of the elderly. Of the 6,503 patients on the chiropodists' lists at the end of the year, there were only 162 handicapped persons and no expectant mother. The 162 handicapped persons is, however, an increase of 42% on the previous year and is likely to be due to a more general awareness of the service.

The proportion of patients certified by their general practitioner as being in need of domiciliary treatment increased slightly — from 27% to 28% — and continued to fluctuate widely between the three areas of the county. The Western area, although the most urban and probably with better public transport than the other areas, had 33.4% of its cases to be treated at home while the northern area, the most rural, had 28.4%. For some unaccountable but nevertheless welcome reason the figure for the southern area, which has always been the lowest percentage of domiciliary cases, has fallen to 21%.

As mentioned earlier, the staffing situation has been better than usual and probably compares very well with other authorities. The establishment of full-time chiropodists is eight, but it has never

been possible to recruit more than seven at any one time. Consequently it has not been possible to implement the County Council's decision that the maximum case load of any of the nine chiropodists, who are in private practice and who treat patients under the county scheme on a per capita or sessional basis, should be 300. This number has been exceeded in three cases. The vacancy has also meant heavy case loads for some of the full-time staff — in one case 848 — and even so at the end of the year 21 patients were on a waiting list for referral to a chiropodist. It is generally accepted that difficulties arise when the case load gets above 600 patients. In this connection Mr. G. H. Thomas, M.Ch.S., S.R.Ch., writes:

“The question of establishing a waiting list for patients depends to my mind on first of all establishing a maximum case load for full-time chiropodists. Assuming an average return period of eight weeks and a sessional treatment of seven, then on a normal ten session week the maximum case load would be in the region of 580 to 600 patients. I must admit that I am not happy at the thought of having patients on a waiting list when perhaps less needy patients are receiving regular treatment by virtue of being there first.

The necessity of increasing the interval between return visits is giving rise to concern. The average interval between domiciliary visits among my patients is three months, which is stretching the benefits of treatment to the maximum limit. Similarly many clinic patients are having to wait a considerable time between treatments although I am reasonably satisfied that urgent acute cases are seen promptly when brought to my notice.”

Mr. Thomas is better able to do this than his colleagues because of the two chair system which he is operating at Whitehaven. He reports:

“The working of a two chair system and the employment of a chiropody receptionist at Flatt Walks, Whitehaven, has continued to work well and this is reflected in the increased number

of treatments at this centre. I would, however, emphasise that the primary aim of the two chair system should be to allow the chiropodist to spend more time on the patients' treatment by eliminating time-consuming non-operative work and not to cram more and more patients into each session."

The two chair system will be extended to other clinics where it is thought to be beneficial but as it needs a duplication of equipment it can only be operated economically at those clinics which are in regular use.

In the past the western area of the county has been particularly hard hit by staff vacancies but during the year under review they have had three full-time chiropodists in post. While case loads have been heavy the comparative stability in staffing has enabled some inroad to be made into the backlog of work as Mr. W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N., reports:

"Because of a shortage of chiropodists there has been some delay in arranging regular clinic and domiciliary visits in the area, resulting in a large number of patients awaiting chiropody treatment. This difficulty has now been overcome and the waiting list for treatment has been reduced to a minimum and there is no immediate problem of absorbing new patients into the present case load.

The result of regular and, in some cases, intensive treatment after considerable delay in getting any treatment has been shown in the greatly improved condition of these patients. In the elderly patients the desirability of constant attendance in maintaining the feet in good repair necessitates regular appointments being made. With the growing number of elderly patients seeking, and receiving, treatment it becomes essential to seek new methods and techniques which will reduce the number of visits and the amount of time that patients have to occupy in order to keep their feet in good condition.

During the year appliances made of lightweight thermo plastic material as well as silicone rubber compounds have been used. The use of "plastazote" in helping to prevent such con-

ditions as erythema pernio by retention of warmth and using the material as insoles has proved beneficial to a number of patients."

On the way she approaches the problem of an ever increasing case load, Mrs. G. Garrett, M.Ch.S., S.R.Ch., writes:

"During 1970 I have tried 'screening sessions' once a month. These sessions are set aside as far as possible for new patients referred during the month and on this first visit they are given an initial treatment and told into which of three categories they fall—namely acute, chronic or pedicure—and the date of their next visit is arranged accordingly. In this way the patients do not expect a set number of treatments per year which they used to regard as their right. Most fall into the chronic category anyway as one might expect".

Clearly, the reduction of case loads to more manageable proportions throughout the county must be given priority when another chiropodist can be recruited, even although the chiropodists themselves believe that in the reasonably near future something must be done about the establishment of a school chiropody service. Mr. F. McCourt, M.Ch.S., S.R.Ch., writes:

"My first impression on joining the county staff, following training, and taking over a case load in the western area was of the unfortunate necessity of having to devote 99% of my time to treat the elderly. This I feel is unfortunate in the respect that the sooner a start is made on preventive treatment in the young the better because these, of course, are the future generations of elderly. I hope that consideration will be given to the possibility of introducing a school service, which will also bring more variety into our work."

Surveys have shown that the absentee rate is about 9%—10% of appointments and it is felt that this is not unduly high when one considers that the patients are almost all elderly. The following comment by Mr. McCourt, a comparative newcomer to the staff, is of interest:

“Attendances on the whole are good, especially in Aspatria where a failed appointment is rare. Early morning appointments are the most unpopular, and failed appointments are most common at these times, especially if the weather is not so good.”

Treatment, whether from full-time or part-time staff, at clinics or in practitioners' own surgeries, is available at the following centres:—

Alston	Maryport
Aspatria	Millom
Brampton	Penrith
Carlisle	Salterbeck
Cleator Moor	Seascale
Cockermouth	Silloth
Egremont	Whitehaven
Keswick	Wigton
Longtown	Workington

The accommodation available for chiropody in Maryport Clinic had given cause for concern for some time and it was, therefore, pleasing to be able to come to an agreement with West Cumberland Hospital Management Committee for the service to be provided from first class co-operation in Maryport Hospital. In particular, the ready co-operation of the matron undoubtedly helped considerably with the smooth transfer. The general reaction of the patients to the transfer has been favourable, although for some time it has meant a slightly longer journey.

Most of the clinics at which chiropody treatment is given were equipped in 1960 or shortly afterwards. At that time equipment was not so readily available and was, in general, of a much poorer standard than can be obtained now. A planned, phased

re-equipment of clinics must be undertaken and it is hoped to begin this in 1971. It has been agreed with the chiropodists that it will be better to concentrate available financial resources on bringing selected clinics up to date in all respects rather than accomplishing part re-equipment over all the premises.

The time spent on travelling to domiciliary cases continues to give cause for concern but it is difficult to see how we can get any really effective reduction in such a rural county as Cumberland. Nevertheless, it is hoped that further voluntary transport can be found to supplement the arrangements in the Seascale area.

The fee has remained at 2/6d. (12½p.) per treatment, whether at the clinic or in a patient's own home. Mrs. Garrett has some thoughts on this subject and writes:—

“I do feel that it would be an appropriate time to consider increasing the domiciliary fee to patients. Those attending clinics have, in the main, to pay a bus fare in addition to their chiropody fee but those being treated at home pay only the basic 12½p. Would it not be sensible to increase the domiciliary fee to, say, 15p? This would help towards running costs and the extra 2½p is certainly much cheaper than any bus fare would be.”

Mrs. Garrett also expresses some concern about the facilities for bus passengers attending Cockermouth Clinic:

“Quite a few rural bus services around Cockermouth are in danger of being withdrawn. The existing services are far from adequate with very long waits between buses. There is no bus station in Cockermouth now and elderly and infirm people really are at a disadvantage, especially in the winter months. I have told patients to use the clinic waiting room if they feel in need of a rest while waiting for their bus connections.”

During the course of the year the authority granted a request by the full-time chiropodists that they should be allowed to undertake a limited amount of private work outside normal working

hours, subject to the reasonable proviso that they should not treat privately any patients who are eligible to be treated under the County Council's scheme. It is hoped that this easing of the conditions of service, together with the fact that a number of the staff have also been given sessional appointments at the hospitals, may help in future recruitment. It certainly makes for happier staff relations.

Judging by the speed at which I receive complaints when the service has to be temporarily suspended in any district because of a staff vacancy, the chiropody service is well established in this county and is quickly missed. All indications are that it is much appreciated by those who need it.

VENEREAL DISEASES

The following is an extract from the report of Dr. H. J. Bell, Consultant Venereologist to the Special Area Committee of the Newcastle Regional Hospital Board:—

“These days, one cannot open a newspaper without reading some sensational account of the ‘V.D. explosion.’ This is a phenomenon of our modern times and our modern society. It is ubiquitous, and could be described as a ‘pandemic’ disease. It is the primary ‘headache of the ‘World Health Organisation’ at the moment. Yet, to be more specific, V.D. in this context, has to be interpreted in terms of one disease — Gonorrhoea. Gonorrhoea now represents a condition both uncontrolled and uncontrollable. The dramatic rise in the statistics of this disease are to be found not only in the more civilised of the world’s communities but, even worse, in the so-called under-developed societies of our world. The only reflection that might bring some comfort is the thought that ‘Thank goodness it is gonorrhoea and not early syphilis’ because were early syphilis to take the place of gonorrhoea at the moment, the results would be catastrophic.

The Cumberland area, including the City of Carlisle itself, has largely escaped involvement in this increase in gonorrhoea. Here, at home, gonorrhoea has presented the usual problems in the diagnosis and treatment of the female, but the overall figures over the last decade have not mirrored the sensational increases so remarkable elsewhere in England and abroad. There has, of course, been an increase over the years, but this increase has been so gradual that our situation, locally, could be pronounced as (luckily) satisfactory.

It is of interest, too, to report that the title ‘Venereal Diseases’ has been dropped as from January, 1971. Possibly the idea here is to change the ‘old fashioned’ image of ‘V.D.’ Departments as the last refuge of the ‘damned’. In future, we are instructed to refer to ‘The Sexually Transmitted Diseases’ instead of ‘Venereal Diseases’ and, in my annual return to the

Ministry of Health, I will be required to report on conditions as variegated as Candidiasis (Thrush), Herpes Simplex, Trichomoniasis, Genital Warts, Molluscum Contagiosum, etc. — hitherto regarded as the trivia dealt with at V.D. Clinics.

The Table following shows the origin of all new patients attending the Cumberland Clinics in the year 1970.

Figures for 1968 are shown in brackets:—

<i>Town or Area</i>	<i>To</i>		<i>To</i>		<i>Total</i>	
	<i>Carlisle Clinic</i>		<i>Whitehaven Clinic</i>			
Carlisle and suburbs	195	(160)	—	(1)	195	(161)
Aspatria	12	(6)	—	(—)	12	(6)
Brampton	12	(7)	—	(—)	12	(7)
Cleator Moor	—	(—)	6	(8)	6	(8)
Cockermouth	—	(1)	5	(7)	5	(8)
Distington	—	(—)	4	(1)	4	(1)
Egremont	—	(—)	4	(7)	4	(7)
Flimby	2	(1)	—	(—)	2	(1)
Frizington	—	(—)	4	(4)	4	(4)
Keswick	17	(12)	1	(—)	18	(12)
Longtown	11	(1)	—	(—)	11	(1)
Maryport	3	(2)	10	(14)	13	(16)
Penrith	27	(25)	—	(—)	27	(25)
Seascale	—	(—)	1	(—)	1	(—)
Silloth	1	(2)	—	(—)	1	(2)
Whitehaven	4	(3)	17	(24)	21	(27)
Wigton	5	(6)	—	(—)	5	(6)
Workington	5	(10)	33	(18)	38	(28)
Others	24	(50)	4	(5)	28	(55)

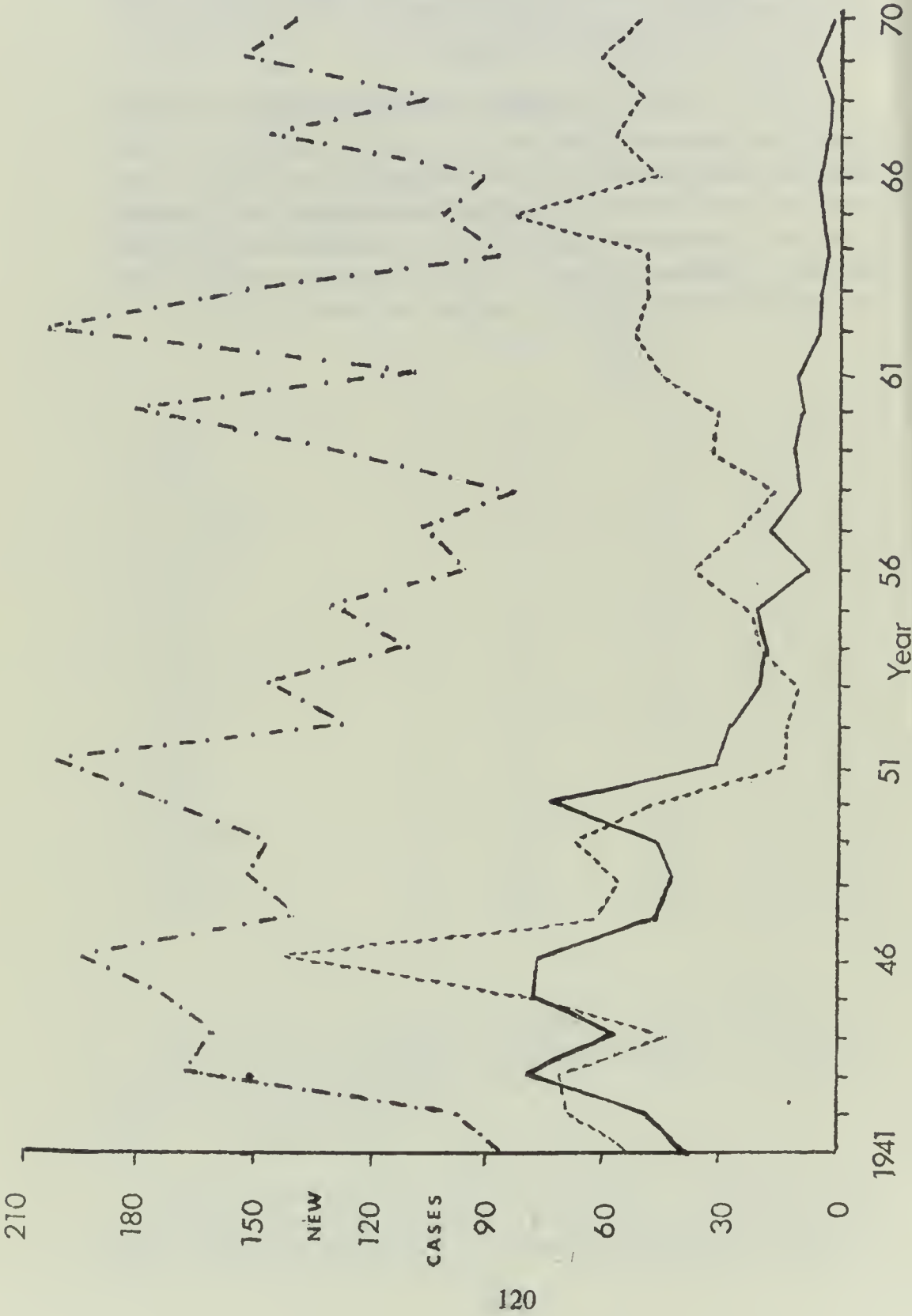
The arrangement whereby local authority staff undertake contact tracing for the hospital authority continues to operate satisfactorily, although this year only 3 cases were in fact investigated in the Western Area.

Normal procedure is for the clinic doctor to telephone the Area Nursing Officer giving details of contacts to be traced. Most of the contracts are female and the tracing is undertaken by a health

visitor. However, where it is necessary to trace a male patient this is usually done by a male home nurse. Over the years this arrangement has proved very successful.

There is no specific programme of health education for venereal disease, but posters and literature are available and these are publicised by health visitors in clinics, doctor's surgeries, etc. Strict precautions are taken to ensure that the display of such material in no way contravenes the Indecent Advertisements Act 1889. The film " $\frac{1}{4}$ Million Teenagers" has been shown in schools in the county and revision lectures for nurses are planned for 1971.

VENEREAL DISEASE — NEW CASES PER YEAR
1941 - 1970
ADMINISTRATIVE COUNTY OF CUMBERLAND



WELFARE SERVICES

WELFARE SERVICES

The provision of services to meet the growing needs of the handicapped and elderly can only be undertaken by the integrated efforts of all those who have some contribution to offer to the total scene. Local Authorities carry the responsibility of developing their direct provision of community services, of helping relatives and friends in their support of the handicapped and disabled of all ages in the community, and of co-ordinating the efforts of voluntary agencies and individuals who are anxious to play their part.

The aim must be the involvement of the community in maintaining the disabled and elderly in their own homes, and this authority has striven to mobilise its resources in man-power by developing teams centred round the family doctor groups so that care can be planned according to assessed medical, nursing and social needs. Linked with this has been the co-ordinating role of my staffs with the hospital and consultant services.

It is a popular misconception to correlate the welfare provision for the elderly with the number of beds available for residential care in welfare homes, or conversely, with the length of the waiting list for such accommodation. Cumberland's overall policy has been directed towards the development of supportive services which would enable the elderly to remain in their own homes and, by so doing, postpone (if not entirely eliminate) the need in individual cases for full residential care. Running alongside this general policy has been a programme of progressive improvement in the quality of the residential provision by replacing former public assistance institutions by smaller modern units. The total effect is summarised by comparisons between the years 1963 and 1970 as follows:—

	1963	1970
Welfare homes for the elderly:		
Public assistance institutions	2 (117 beds)	—
Adapted premises	5 (113 beds)	4 (95 beds)
Purpose designed homes	3 (114 beds)	12 (349 beds)
	<hr/>	<hr/>
	10 (344 beds)	16 (444 beds)

Group housing schemes for the elderly with warden oversight	4 (107 places)	14 (322 places)
Elderly (over 65) receiving domiciliary nursing services	2,933	4,825
Elderly (over 65) receiving domestic help	834	1,341
"At risk" elderly receiving day care in welfare homes	5	73
Meals Services:		
In day centres and luncheon clubs	2,662	20,320
Meals on wheels	12,142	63,734
	<hr/> 14,804	<hr/> 84,054

The emergence of Departments of Social Service in the near future will mean that the channels of communication between the new local authority department and the three arms of the National Health Service will have to be reorientated. These changes in the organisational structure within Local Government have already necessitated long and detailed study and re-appraisal, so that the transition can be effected without detriment to the service available to the client and in the spirit of a more generic approach to the social support of the entire family in the community.

RESIDENTIAL ACCOMMODATION

(a) For the elderly

The Council's policy during the past decade has been directed towards the replacement of large centralised institutions (which were used by the local authority to provide residential care for those in need of "care and attention" and by the hospital authority for the medical and nursing care of the aged) by smaller purpose designed units which offered welfare accommodation on a neighbourhood basis. The primary objective was reached in 1969, by which time 324 units of accommodation were provided in 11 modern buildings and 95 in four premises which had been adapted for the purpose — a total of 419 places. During 1970 another new Home (Ravensfield, Keswick) came into use and provided a further 25 places.

Because it was felt necessary to improve the quality of the facilities provided it should be noted that the total provision at the end of the year under review (444 places) was only 21% greater than at the end of 1960 — despite the continually increasing numbers of elderly people in the total population coupled with a persistent decline in the support available to them by caring relatives because of outward migration, particularly of the families of mobile wage earners, from this rural area to job opportunities elsewhere.

In retrospect the decision to concentrate on the closure of institutions which were unacceptable by modern standards and unsuitable for contemporary needs in the face of mounting waiting lists, has been justified. The quality of service now available in modern units ensures that the correlation of old age and poverty becomes a memory. It can confidently be expected that the total provision will increase by almost 50% during the next five years by the development of new homes.

(b) For the handicapped

Alneburgh House, Maryport which was opened in 1968 to cater for 20 younger physically handicapped residents has contained the present demand for such accommodation within the Administrative County, in that it has not been necessary to seek placement for County residents outside the area. Sixteen of the places are allocated to long-stay residents, the other four being utilised for offering care of relatively short duration to meet social emergencies, to provide temporary relief to caring relatives and for holiday purposes. It should be noted, however, that there is no margin of reserve of accommodation for those requiring long-term care and there are indications that the demand for the short-term provision are beginning to out-strip the availability.

The Workshop which forms an integral part of this Home has proved to be valuable therapeutically and has helped to maintain the morale of the residents. It is available to non-residents living within a reasonable travelling distance of Maryport although the demand for this service has been quite small.

(c) For the homeless

The provision of temporary accommodation for the homeless, unlike the experience of the larger conurbations, does not constitute a major problem in Cumberland. The need is largely contained within the client's normal area of residence with the ready co-operation of the County District Councils as housing authorities.

During 1970 it was necessary to provide temporary accommodation for 12 families in all consisting of 53 persons. It is interesting to note that the number requiring such accommodation at any one time has remained fairly static as is illustrated by the fact that at the beginning of the year 2 families (16 persons) were in family units and that at the end of year 3 families (11 persons) were similarly accommodated.

REGISTERED HOMES

Three homes were registered under Section 37 of the National Assistance Act 1948 at the close of 1969. One (Scalesceugh Hall, Carleton, Carlisle) provides 30 places for adult spastics and is run by the local Spastic's Society. Two others (Rothersyke, Egremont and Springbank, Braithwaite) provide 20 and 10 places respectively for the care of the elderly.

During 1970, registrations were approved for a further two privately run Homes for the elderly — at Salutation House, Heads Nook, Carlisle (6 beds) and at the Croft Rest Home, Kirk-santon, Millom (19 beds).

SPECIAL HOUSING FOR THE ELDERLY

(a) Supported Independency Schemes

Special housing schemes for the elderly have been developed during the past ten years primarily by the County District Councils as housing authorities, either in bungalow or flatlet form to cater for the special needs of elderly tenants. This practical housing provision has been supplemented by communal welfare facilities with the support of the County Council as the welfare authority not the least of which is a resident warden who keeps a regular watchful eye on the tenants who are able to summon her assistance by means of a call-system at any time.

This type of scheme makes an obvious and valuable contribution to the total spectrum of care for the elderly in that it enables them to remain within the community in comfort and security whilst retaining their personal independence.

Many of the problems associated with old age such as loneliness, isolation and unsatisfactory accommodation can be met by proper housing, linked with easily accessible supportive services and may postpone, if not eliminate, the need for full residential care.

By the end of 1970, 14 developments of this type in the County provided 322 places. Five others have been planned — three of which should be available during 1971 and the others early in 1972 by which time the total provision will be 462 places.

The financial contribution which the County Council makes to District Councils towards the maintenance of the welfare provisions in special housing schemes was reviewed during the year in the light of increasing costs.

(b) Housing Associations

An interesting development during the year has been the emergence of a number of special housing schemes for the elderly by non-profit making housing associations. This prompted my

Committee to consider the desirability of encouraging these enterprises by making a contribution towards the welfare aspect of their work. With the approval of the (then) Ministry of Housing and Local Government under Section 119 of the Housing Act 1957 it was agreed that an annual grant of £10 be paid for each unit of accommodation provided in any suitable scheme for which financial help was sought by a Housing Association—the minimum requirements being a provision of a resident warden and a call bell system.

Two Abbeyfield Society homes, at Whitehaven and Keswick, each catering for five single elderly residents, qualified for the grant during the year and a larger purpose built scheme was opened by the Hanover Housing Association at Penrith towards the end of the year which provides 19 self contained flatlets. Three other private Housing Associations (at Penrith, Seascale and St .Bees) propose to acquire and convert premises to this purpose in the near future.

HANDICAPPED PERSONS

The numbers of persons registered with the Authority as permanently and substantially handicapped continues to increase, the totals for the past five years being:—

1966	...	...	522
1967	...	...	614
1968	...	...	689
1969	...	...	735
1970	...	...	838

There were 156 new registrations during the year of whom 77 were 65 years of age and over, only 31 being under 50 years. Almost one third of those registered are classified as suffering from organic nervous disease and about one fifth from arthritis or rheumatism.

Whilst hitherto admission to the register has been on the application of the client, the Chronically Sick and Disabled

Persons Act 1970 will (when Section 1 is implemented) require the Local Authority to seek out and register those who may require the services which the Act envisages. The rate of growth of the local register gives some indication of the efforts which have already been made, mainly through the family health care teams and social workers, to identify those handicapped persons in the community who might benefit by the wide range of services which have been available locally under the existing scheme. It is interesting to note that the mandatory provisions of Section 2 of the new Act have been available in this area since 1954, albeit of a permissive nature and governed by the availability of finance, and with the exception of those items relating to the provision of telephones and television receivers.

The involvement of voluntary organisations in the support of the handicapped within the community has been demonstrated in a most encouraging fashion by efforts resulting in the acquisition of special transport to facilitate the participation of the various groups of disabled in social and other activities. A new vehicle, designed to carry five chairborne or eight seated passengers and equipped with a rear lift was purchased following fund raising efforts sponsored by the Whitehaven Rotary Club, manning of the vehicle being undertaken by a pool of volunteers. A former field ambulance was acquired by the Workington Round Table and equipped with a hydraulic lift for the transportation of chairborne clients. This was handed over to the County Council for use by the handicapped, a term which in this case was to be liberally interpreted to include the elderly.

As can be expected the number of disabled car drivers qualifying for the issue of the special car badges to assist in overcoming parking problems has again increased, the total at the end of 1970 being 95 by comparison with 86 in the previous year.

SHELTERED EMPLOYMENT

For some time it has been apparent that the facilities for the sheltered employment of the substantially handicapped were inadequate and my Committee has considered the establishment of a 50 place workshop to serve the area of greatest need, to be located in a developing industrial complex at Lillyhall near Workington. Having been allotted a provisional place in the Capital Development Programme for 1971/72 a detailed survey of possible clients was undertaken with the considerable assistance of the Department of Employment's Disablement Resettlement Officers. Consideration was also being given by the Department of Employment to a possible extension of the Remploy Factory at Cleator Moor to provide a further 30 places.

The survey covered two main groups (a) those already listed by the Department of Employment as in need of sheltered employment and (b) those "substantially and permanently handicapped" on the local authority's registers who were not registered with the Department of Employment and who, it was felt might be employable under sheltered conditions.

A preliminary analysis of the survey findings indicates that the need is at a level which would seem to justify both the extension of the Remploy Factory and the establishment of a new local authority workshop providing about forty to fifty places. The need has therefore been amply demonstrated but in view of the considerable revenue implications the Council's policy in this matter will be considered at an early date.

BLIND AND PARTIALLY SIGHTED PERSONS

The domiciliary supportive services for the blind and partially sighted are undertaken by four qualified Home Teachers of the Blind with the support of the all purpose social workers. The Barrow, Furness and South Cumberland Society continues to act as agent for the Council in this respect in the Southern part of the County.

Unlike the register for the sighted handicapped the register of blind persons is considered to be comprehensive. This is reflected in the relative stability of the total which has marginally declined, both nationally and locally, during the past ten years. During 1970 fifty persons were newly registered as blind and twenty two as partially sighted. The totals registered at 31st December, 1970 were 469 and 176 respectively. Of these three quarters of the blind and rather more than half of the partially sighted were over 65 years of age.

BLIND HOME WORKERS

Two of the three blind home workers (a pig breeder and a pet shop food proprietor) who are included in the Council's scheme for blind home workers, achieved earnings to a level which justified their retention within the scheme and, accordingly, augmentation of their income by the County Council at the approved scale. Although the third home worker failed to reach the qualifying level of earnings as a smallholder the Committee agreed to his retention in the scheme for a further year at maximum augmentation rates.

WORKSHOPS FOR THE BLIND

The transformation of these workshops from a centre pursuing traditional crafts to a modern factory applying industrial techniques has been a continuing and rewarding process since the administration was taken over from the voluntary association by a joint Sub-Committee of the Councils of the City of Carlisle and this authority in 1962.

This has involved a continual reappraisal of the products, the elimination of unprofitable items for which there was both limited outlet and declining demand and the retraining of the employees in modern manufacturing skills geared to more viable products. Concurrently the internal arrangements within the actual workshops have been redesigned from a series of individual workrooms to an open planned factory offering greatly improved workshop conditions and more efficient operational control.

The firewood, knitting, basketwork and piano tuning sections—all traditional blind occupations—have been closed and replaced by two major production units, one manufacturing a wide range of mattresses and divan beds, the other dealing with upholstery. This latter department undertakes the renovation of antique and modern upholstered furniture and the direct manufacture of a comprehensive range of upholstered stools, chairs and settees.

The success of these endeavours can be measured in many ways, not the least of which has been the visible improvement in the morale and wellbeing of those employed in the workshops resulting from greater job satisfaction in the knowledge that the goods produced are of first class quality and in heavy demand. From a more material aspect, the sales have increased from £19,000 in 1963 to £38,441 in 1970 although the work force has declined from 30 to 27 approved workers and trainees.

Improved facilities for training the blind or partially sighted to take their full place in open employment, coupled with a reduction in the incidence of blindness, have led to a significant decline in the need to provide sheltered employment facilities for this group. At the same time this has been more than counter balanced by the number of sighted disabled persons, especially those suffering from psychiatric handicaps, who can only be employed under sheltered conditions. With the approval of the Department of Employment, the Workshop facilities have been widened to include a higher proportion of sighted disabled in the total of approved workers. The rate at which this change has taken place is illustrated by the following figures.

	Blind and Partially Sighted	Sighted Disabled	Trainees	Total
At 31st Dec., 1963	26	3	1	30
At 31st Dec., 1970	15	7	5	27

It is also appropriate to note that of the five persons at present under training only one can be classed as blind or partially sighted.

DEAF AND HARD OF HEARING

The Carlisle Diocesan Association for the Deaf acts as agent for the County Council in the provision of welfare services for the profoundly deaf. The area covered by the Association embraces the Counties of Cumberland and Westmorland, the Furness area of Lancashire, the County Borough of Barrow in Furness and the City of Carlisle, the total costs being borne by the local authorities on a per capita basis.

The register of the profoundly deaf varies little from year to year and at the end of 1970 in the Administrative County there were registered 39 deaf persons with speech and 78 deaf persons without speech.

In this specialised field my Department's field workers naturally look to their colleagues in the Diocesan Association as being the expert case workers among the profoundly deaf in the community. I have been pleased to note the continuing co-operation and mutual support which exists between the association's officers and my own staff in cases of multiple handicap which include deafness and close liaison is maintained with the peripatetic teachers of the deaf from the Education Department.

Over the years it has become apparent that the hard of hearing seem to be well integrated in the community and enjoy activities within normal ranges so that special facilities are not in demand. Probably the most fruitful assistance which could be offered to this group would be in relation to initial guidance in the use of hearing aids and instruction in their care and effective maintenance but this is under active consideration, I understand, through the hospital service as an extension of their current responsibility for the issue and repair of hearing aids. The number of persons registered as being hard of hearing has slowly increased during recent years, the total at the end of the year under review being 26.

DAY CENTRES, LUNCHEON CLUBS AND MEALS ON WHEELS

Day Care

Whilst there are no separate day care centres in the County, every new Home built during recent years has been designed to provide facilities for a limited number of elderly to be offered day care services. The extent of this provision in each Home must be carefully balanced, weighing the increasing demands for the service against the necessity to respect the privacy of the residents. I think it can be safely said that our experience indicates that the day visitors are generally welcomed by the residents in that they bring local news and information into the Home and provide new topics for conversation. The benefits accruing to the recipients can be seen in their practical application — good food, bathing, hairdressing and chiropody-quite apart from companionship. Not infrequently day care for as little as one or

two days a week can so influence the total situation that the necessity for full care is postponed and may even be removed. Eleven homes are now able to offer this service (two more than in the previous year) and by the end of the year 73 elderly people were receiving day care to varying degrees from one to seven days a week — the corresponding figures for 1969 being 36.

Luncheon Clubs

Seventeen luncheon clubs for the elderly are in operation throughout the County. Of these seven are run by Old People's Welfare Committees, four by the Women's Royal Voluntary Service, the remaining six being organised by the Matrons of Old People's Homes in which these clubs are held. A total of 35,802 meals were provided during 1970 which represents an increase of 28% over 1969.

Meals on Wheels

This service has the primary aim of making a contribution towards the nutritional needs of those elderly who are isolated

because of illness or infirmity but also serves to support the help given to the housebound by caring relatives, friends and neighbours. It can also be brought into operation in a purely temporary fashion to meet short term requirements e.g. whilst a spouse is in hospital or whilst supporting relatives are on holiday etc.

The Council's gratitude to the Women's Royal Voluntary Service for undertaking this heavy commitment in Cumberland cannot be over-stated. This has grown from about 300 meals delivered during 1959 to nearly 64,000 in 1970. More than 500 members give unstintingly of their time and energy in many ways so that a nourishing meal can be delivered to the recipient and, what may be equally valuable, personal contact made in the home.

Both in relation to the numbers of persons in the over 65 category who were served with meals and as regards the numbers of meals provided to this group, Cumberland's record is significantly higher than the average for English Counties, despite the additional problems of large distances and sparse populations. The future of this service demands urgent reconsideration — the need is apparent but further growth is being restricted by financial stringencies and by the dependence on further voluntary effort to bring the number of meals served per week to each recipient to a level which would make a more significant contribution to their nutrition.

MENTAL HEALTH

MENTAL HEALTH

Two important pieces of legislation came on to the statute book during the year — the Local Authority Social Services Act 1970 and the Education (Handicapped Children) Act 1970. The former proposes to transfer the mental health functions of local health authorities to a new Department in local government with a wide remit for personal social services, and the latter will hand over to education authorities functions concerning the education of mentally handicapped children which have been carried out by local health authorities since 1927. Both these measures will come into operation on the 1st April, 1971 and in the light of these impending changes in the structure and organisation of the mental health services, the year under review has been occupied more in consolidation and in preparation for a smooth transition than in attempting to break new ground.

The support of the mentally disordered in the community has been pursued by my staff working in multi-disciplinary teams associated with family doctors and in close association with the hospital and consultant services. The emergence of a more generic approach to a wider range of social services has obviously demanded discussion in some depth with the Director of Social Services to ensure the continuation of service at the high levels currently established but geared to the requirements of the changing scene.

The total case load of the mental health service at the end of the year, as may be expected, reached a record number of patients or clients viz 1059. When this figure is broken down into its main groups, it is noted that the number of mentally ill or psychopathic clients has remained fairly constant at about 450 during the last five years, having increased to that figure from 1960 when the Mental Health Act 1959 imposed a duty on local health authorities to provide care and after care services for this group. The numbers of mentally handicapped persons in the community requiring supportive services has varied between 449 (in 1965) and 547 (in 1970). A third group, introduced for statistical purposes in 1966 but undefined, is categorised as “elderly

mentally infirm” — the total in this increasingly important group who were receiving social work support at the end of the year being 86.

Junior Training Centres

Consideration of the desirability or otherwise of transferring the responsibility for the education of the mentally handicapped children to the education authorities has been exercising the minds of governments and their Ministers for many years. The decision has now been taken and what were originally “occupation centres” and later became “junior training centres” for the sub-normal under local health authority management will become special schools within the education system in April 1971. The first effect of the new legislation is to remove what has been a most difficult requirement in relation to mentally handicapped children — the legal necessity to record that a child is “unsuitable for education at school” and by so doing, deny the child participation in the educational system. The recording of such a decision has always been a traumatic experience for parents already distressed. The fact that every child will in future have access to educational opportunities is obviously compassionate and educationally sound. The mentally retarded child will now share the same basic right for education according to ability.

Flowing from this decision, the junior training centres will become special schools with a new scope for development. The teaching staffs will undoubtedly benefit by more direct access to specialist facilities and from closer association with teachers in other spheres of education. The provision of training facilities for mentally handicapped children has always been accorded a high degree of priority by my Committee. The education authority will take over two modern purpose built units at Wigton (45 places) and at Whitehaven (75 places). This represents a total provision per 1,000 of population (0.55) which is slightly in excess of the projected national norm for 1976. Attendances at these Junior Training Centres reached a peak of 16,251 in 1970 — an increase of nearly 13% over the previous year. At the end of 1970 there were 96 children on Junior Training Centre registers and 16 severely handicapped children receiving “special care” on a part

time basis at the Hensingham Unit. It can reasonably be expected that the present provision will be adequate for at least a few years to come.

Hostel Provision for Subnormal Children

The Hostel at Orton Park was opened in 1959 as a full time unit, its main objective being to provide boarding accommodation so that mentally handicapped children living in the more remote areas in the County could attend a training centre. The hostel facilities were so little used at weekends and during holiday periods that it was decided towards the end of 1963 to keep it open only when it was necessary to enable children from the outlying areas to participate in full time training. In this capacity it has been invaluable because no child need be denied full time training for geographical reasons. Since to this extent it has operated simply as a boarding annexe to the Wigton Junior Training Centre — a need which will apparently continue — it has been decided that it will be taken over by the Education Department in April 1971.

The hostel provides 22 places and was only fully occupied on very rare occasions during its first ten years, but towards the end of 1969 and continuing throughout 1970, all the places have been taken up. The average age of the boarders has fallen quite dramatically during the last two years being just under 9 years at the end of 1970 and, since the two oldest boarders will not reach the statutory school leaving age until 1972, there are no vacancies expected within the next two years. It had been the Health Committee's intention to replace Orton Park by smaller purpose designed units in the 1971/76 period and the Director of Education will doubtless be reviewing this aspect of his new commitments in relation to mentally handicapped children in the near future.

HOSTEL ACCOMMODATION

For Subnormal Adults

Considerable emphasis has been placed, quite rightly, on the need to increase the provision of hostels for the subnormal in adult life so that patients can be discharged from the psychiatric hospitals for the subnormal when nursing or medical care is no longer required and to provide accommodation when the need arises from social factors such as the death, or inability to cope, of a caring relative.

To this end the Council proposes to develop two such hostels — at Workington during the 1970/71 Programme and at Carlisle in 1972/73. Both will provide facilities for 20 residents. The location of hostels for the mentally disordered is never easy and almost invariably arouses opposition from local residents. This happened at Workington during the year but the difficulties were resolved by meeting the local objectors and explaining the purpose and functions of the proposed development. It is expected that building will commence in the early part of 1971. No site has yet been found for the hostel which will serve the northern and eastern parts of the County but, in the absence of any convenient conurbation in these parts and since Carlisle presents a suitable focal point, it is hoped to acquire a site within the City.

For the Mentally Ill

The hostel at Whitehaven ("Fairview") was opened in 1966 to provide a secure environment for the resettlement of the mentally disordered in the community after hospital treatment and to provide temporary accommodation at times of social crises for those in the community who were suffering from a mental illness which did not require treatment in hospital. This was a relatively untried provision and, since the level of demand was uncertain, the hostel was built for 17 residents and designed in such a way that its capacity could be easily increased to 30 if necessary. The following tables give statistical data to date:—

	1966	1967	1968	1969	1970
Average weekly occupancy (%)	42.7	59.6	71.2	86.0	96.4
Admissions					
From Garlands Hospital	15	5	16	18	2
From West Cumberland Hospital	2	4	4	7	4
From Dovenby Hall Hospital	—	—	2	1	—
From home	12	8	7	15	14
Re-admissions from seasonal employment	—	2	6	4	4
Others	—	—	1	6	5
	29	19	36	51	29
Discharges					
To residential employment	4	5	10	9	6
To home, relatives or lodgings	5	12	15	23	15
To hospital	6	5	6	13	4
Absconded	—	2	—	2	—
Died	—	—	—	1	—
To other Welfare Homes	—	—	—	—	4
	15	24	31	48	29

In terms of numbers rehabilitated to a normal life in the community, the hostel can claim to have been successful in that 93 people have been able to return home, to relatives, into lodgings or residential work. This figure represents just over 70% of all admissions and is the result of a most determined and very commendable effort by the hostel staff and the social workers in an area of high unemployment.

During its earlier years the main problem surrounding this hostel was that of underoccupation and although this has been resolved (as is evidenced by an average occupancy of more than 96% during 1970) this economic use of the unit has only been achieved by alteration of the original selection procedures. I think there is now sufficient experience, following five years' operation, to reach the conclusion that the size of the hostel is adequate to meet the likely demands for rehabilitative functions and temporary care for those recovering from mental illness in the West Cumberland area. The opening of a hostel in Workington to cater for those adults who are mentally handicapped will reduce the calls on Fairview which recently has accepted a limited number of resi-

dents whose mental disorder is subnormality. It has been encouraging to note that the average age of the residents has declined from nearly 55 at the end of 1969 to 47 years at the end of 1970. The introduction of a limited degree of day care at the hostel during the year has been welcomed in that it has afforded relief for some families, and direct help to the client living alone.

ADULT TRAINING CENTRES

Cumberland's only training centre for subnormal adults was opened in 1965 at Distington and provided 50 places. This was enlarged in 1969, as part of a planned two-phase development, by the addition of a further workshop area and a wing to improve the educational facilities, with some redistribution and improvement of the outside working areas. The centre now has a capacity for 80 trainees. There is no direct provision in the more sparsely populated parts of the County to the north and east but, by arrangement with the City of Carlisle, those adult subnormals living within a reasonable travelling distance of the City received training at that authority's centre at Kingstown. The total provision is below the national norm but the deficiencies arise only in those parts of the County which require boarding accommodation to be linked with the training provision. It is hoped that discussion with the Carlisle City authorities may result in mutually beneficial developments.

The extension of the Distington Centre presented the opportunity of reorganising the internal organisation and of reviewing the staffing requirements. On the recommendation of the Management Services Unit a Manager was appointed to take overall charge of the running of the Centre. This relieved the training staff of organisational responsibilities to that they could devote their time exclusively to training under the direction of the Manager. A part time Clerk was also appointed.

The additional working area has enabled more sophisticated wood-work machinery to be installed which in turn has allowed greater diversification of products. In the new workroom a line

system has been introduced for the production of incontinence pads which provides useful training for some of the less capable trainees and there is a developing demand from local industries for the manufacture of wooden pallets.

It has been the policy to ensure that the continuing social and further education of the trainees should not be subordinated to practical training — the aim constantly being to strike an appropriate balance between these functions. The reorganisation of the staffing levels, coupled with greatly improved accommodation have made it possible for a senior member of staff to devote most of his time to a carefully structured programme of social and further education of the trainees in small groups. Every trainee spends a minimum of three half-hour periods each week in the classroom.

The range and content of semi-industrialised occupations during the year are summarised below:—

Fabricated from basic materials:—

Wooden products:-	Fencing panels (interwoven)	1,726
	Fencing panels (ranch type)	59
	Pallets	372
Wire Products:-	Wire frames for packaging	218,910
	Wall ties	5,700
	Coathangers	59 gross
Concrete products:-	Paving flags	1,906
	Plant pots	46
	Edging stones	69
Paper products:-	Incontinence pads	22,900

In addition, special orders for boxes and notice boards were completed for the County Fire Service.

Sub-contract and assembly work

Forms printed for County Council Departments	484,000
Accumulator plugs assembled	2,061,490
Plastic salt and pepper pots assembled	175,563
Hospital packs prepared for auto claving	9,227
Assembly and packaging of seat belt parts	22,740

AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

“It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or expectant or nursing mothers from places in their area to places in or outside their area.”

COUNTY AMBULANCE SERVICE

ANNUAL REPORT

The Ambulance Service has continued to develop during 1970 in the context of a variety of events affecting the short and long term progress of the service. These included the production of the interim report of the Management Services Unit which had been asked soon after its institution in Cumberland to examine certain aspects of the operation of the Ambulance Service with a view to defining any areas in which increased efficiency might be attainable. At the same time the pattern of training of ambulance personnel was maturing in the establishment of a Regional Training Centre in Newcastle alongside the local continuation of advanced training established in the county in recent years in conjunction with the major accident hospitals. In the field of day by day operation, the service was affected for the first time in many years by an industrial dispute which embraced all local authority manual workers. All of these events and many others I deal with in a little more detail below.

The interim report of the Management Services Unit recommended the termination of the contractual arrangements operating at Cockermouth, Maryport and Keswick. At a special meeting of the Health Committee it was agreed to accept the recommendations and, as a temporary measure pending the final report of the Management Services Unit, to provide cover for the Cockermouth and Maryport areas from Maryport. The contractor was accordingly given notice terminating his contract as from 31st March, 1971. These proposed changes caused some local anxiety and members of the Health Committee met district and urban representatives in order to fully explain the proposals. Negotiations are proceeding for the acquisition of temporary premises at Maryport.

With regard to Keswick it was decided that, provided premises suitable for adaptation and use as an ambulance station were available, the contractual arrangements be terminated. Premises have been found and notice has been served on the contractor terminating the arrangements as from 30th September, 1971.

It was felt there were no grounds for altering the present contractual arrangements at Alston.

The need for the service increased by 7,480 patients (6%) due mainly to an increase in the number of elderly patients being conveyed for day care to the various health establishments throughout the county. Mileage has increased by 18,377, only 1.5%. This has been due to the opening of the Artificial Limb and Appliances Centre at Cumberland Infirmary, Carlisle, on 8th September, 1970. Apart from the saving in mileage the establishment of this Centre, largely contributed to by continued representation from the Health Committee, represents a considerable easing of the burden of those disabled, the majority of whom are elderly, who in the past had to make the long and tiring journey to Newcastle.

Mr. N. Brereton, a patient who has travelled frequently to the Artificial Limb and Appliance Centre, Newcastle, writes:

"The change over from Newcastle to Carlisle of the Artificial Limb and Appliance Centre, cutting the journey by half, is a great advantage. The service provided by private cars and the comfort is excellent and very much appreciated. You provide a service that cannot be done without."

The increase in mileage would have been less but for a sudden upsurge in the number of journeys to the Kidney Unit at the Royal Victoria Infirmary, Newcastle. The treatment of these patients generally lasts for 12 hours so that a journey at each end of the day is necessary. The position is being reviewed in an attempt to find means of reducing the amount of travelling necessary.

The continuing co-operation of the Hospital Authorities, especially in relation to the service provided in Millom, where difficulties arise due to its geographical position, is referred to by Mr. G. McGarry, the Officer in Charge of the station there, when he writes:

"During the past few months there has been much more co-operation between clinics at West Cumberland Hospital and

ourselves and patients from the Millom and Bootle districts are, as far as is possible, dealt with promptly, thus enabling Millom vehicles to be back in the town in ample time to deal with afternoon work.

The Hospital Car Service is still a major factor where Millom is concerned and the operators are to be commended for their treatment of all patients, some of whom can be difficult."

The views expressed by Mr. J. Corry, Station Officer, Penrith, sum up the attitude of everyone in the Ambulance Service to this work:

"Our work with our senior citizens, disabled persons and those in need of special care has increased greatly. We have transported the elderly and other less fortunate persons to a variety of classes and functions, such as day care centres, occupational therapy centres, disabled persons' classes, etc. We are justly proud of the patience, sympathy and compassion extended to these patients by the ambulance crews.

During the period of dispute in the electricity industry ambulance crews carried out a watching brief, making sure that none of the elderly or disabled were in need of heat or food. Our colleagues in the Welfare Department were informed of any who required help.

The aspect of the service that has pleased me most has been the fact that the Ambulance Service has been so far accepted as the experts in the handling and transportation of sick and injured persons in so much as the Police and Fire Service have invited the Service to provide instructors to take part in their own training programmes."

In May Dr. K. Easton, Richmond, Yorkshire, addressed a meeting of general practitioners at the Penrith Hospital on the functioning of the North Riding Accident After Care Scheme. Further meetings were held with general practitioners in the Penrith

catchment area regarding the formation of a similar scheme involving the attendance of doctors at road accidents. Representatives of all the other bodies involved attended and, although the final arrangements have been agreed, it is not expected that the scheme will operate until later next year when doctors have the necessary equipment but already one group practice has provided its own radio operating on the Ambulance Service frequency. A similar arrangement is now operating in Maryport.

Dr. H. Barr, Penrith, who has played a leading part in these arrangements, writes:

“It may be difficult looking back but it is equally difficult trying to look forward to the changes that are likely to occur in general practice. A necessary change in general practice will surely reflect change in the ambulance service. One field in which general practitioner and ambulance personnel will be closely associated in the future is in dealing with serious accidents. This will surely apply increasingly in country areas where it takes time for any form of flying squad to reach the scene of the accident, and where there are already doctors available to attend to these accidents. In this situation the working of the general practitioner with the ambulance personnel can only enhance the medical team in the care of the seriously injured. Perhaps this service will be extended eventually, if patients in the rural areas are to receive the same facilities as their brethren in the cities, to acute myocardial infarction and other medical emergencies.

I am sure that, in the future, the association of the general practitioner with the ambulance service will continue to be a special one, but it is important, as they have done in the past, to keep the welfare of the patient in the forefront of their thoughts no matter in what situation they may find themselves.”

Arising from the completion of the motorway throughout that part of Westmorland covered by the Penrith Station the manning arrangements of this station were reviewed and it was decided, because of the risk of multiple-type accidents, generally associated with motorways on the more exposed parts around

Hardendale and also because the Management Services Unit recommended an extension of the manning of the station until midnight, that the station should be manned on a 24 hour basis. The Chief Constable had already expressed his concern over possible delay in clearing the motorway in the event of an incident under the present arrangements. Negotiations are being held with Westmorland to find a mutually agreed basis for the allocation of the additional costs involved.

In making arrangements to deal with incidents on the motorway there was close co-ordination with the Police and Fire Services. In order that necessary measures can be continually reviewed, an Emergency Services Liaison Committee has been established at which problems of mutual concern are discussed.

The Ambulance Service in Cumberland did not escape the effect of what came to be known as the "dustmen's strike". A work-to-rule operated from Monday, 5th October, which meant that no overtime was worked and no cover provided for sickness, leave, etc., of crews on non-emergency duties. The effect of this on the service in West Cumberland was a curtailment of the non-emergency work for West Cumberland Hospital involving the cancellation of a geriatric clinic on Tuesdays, a reduction of a geriatric clinic on Thursdays and the withdrawal of transport for patients attending the day hospital at Whitehaven on Thursdays and Fridays. Certain elderly people normally conveyed to a day centre in an Old People's Home and also the handicapped normally transported to the Workington and Whitehaven Clubs were also victims of the situation. The particular services curtailed were agreed with the staff at West Cumberland Hospital on a priority basis. A few individual members of staff at Wigton and Penrith Ambulance Stations also applied the work-to-rule but this was not sufficient to affect the level of service from these stations.

The Western and Southern Area Medical Officers were kept fully informed with regard to the names of those patients whose transport had been curtailed so that nurses and social workers were able to do everything possible to alleviate hardship in the

domestic situation. Instructions were issued that no action should be taken in organising other staff or voluntary workers to provide alternative transport nor was the volume of work done by the Hospital Car Service increased. This course of action was adopted to avoid a deterioration in the general situation.

The use by ambulance crews of Entonox is now being introduced on a limited trial basis in East Cumberland. This equipment gives a mixture of nitrous oxide and oxygen in equal parts which can be offered by ambulance crews for self-administration to certain types of road accident casualties, chiefly those who are trapped and in severe pain. This follows on from an evaluation of the equipment by the Consultant Surgeon, Accident and Emergency Department, Cumberland Infirmary, who, together with a Consultant Anaesthetist, had been asked to undertake the necessary training of the ambulance personnel in its use.

During the year 17 births, most of them in ambulances, were satisfactorily dealt with. This is a very sharp rise over the preceding years and a departmental investigation is being held to establish if there are any particular reasons for this trend and if it is likely to continue.

Training

A report by the Local Government Training Board on Ambulance Training Centres suggested either the establishment of four large training centres at which all courses could be concentrated or that the courses should be held at 12 smaller centres thereby making maximum use of the existing facilities. There was general agreement on the latter suggestion which included the establishment of a Training Centre at Newcastle upon Tyne.

The possibility of the establishment of this Training Centre, which would eventually be able to cater for all Cumberland's basic training needs, had already been considered by the Health Committee, who decided that it should be fully supported.

This year six ambulancemen attended six-week courses at the Lancashire and West Riding of Yorkshire Training Schools and

the subsequent reports on their achievements showed that they obtained an excellent standard which reflected great credit upon themselves and the Cumberland County Ambulance Service.

Ambulancemen in both East and West Cumberland continued the one-week in-hospital training programme and plans are now in hand to commence another series of lectures in Advanced First Aid at the Cumberland Infirmary, Carlisle.

An arrangement has also been made with the Chief Constable for a two hour lecture on the County Ambulance Service to be included in the syllabus at the Police Training School, Penrith. This is given by Mr. J. Corry, Station Officer, Penrith; one hour is devoted to the organisation and operation of the service and followed by an hour's visit to the ambulance station.

Stations

The building of a new station at the Cumberland Infirmary, Carlisle, to replace the present unsatisfactory premises at Bush Brow is well under way and is expected to become operational in July, 1971. I feel sure no-one will be more pleased than the drivers who have worked most cheerfully and efficiently under what at best can only be described as "unsatisfactory conditions".

At Keswick, because of the inability of the local St. John Ambulance Brigade for various reasons to provide volunteers to act as attendants on emergency ambulance journeys, it was necessary to increase the contract figure from £2,200 to £2,950 from 1st October, 1970, to allow the Contractor to meet this additional commitment.

I wrote to the Divisional Superintendent of the St. John Ambulance Brigade on behalf of the Health Committee thanking him for all the excellent and devoted work done by himself and his members during past years, which we all have greatly appreciated.

Vehicles

During the year orders were placed for one traditional ambulance and three dual purpose vehicles. Two traditional ambulances and four dual purpose vehicles have been received but these include vehicles ordered in 1969/70. The delivery of these vehicles after such a long delay due to national industrial difficulties was very much welcomed as this will go some way towards ameliorating what had become a difficult maintenance problem.

One more ambulance and one more dual purpose vehicle are still awaited.

It is not, at this stage, intended to dispose of those traditional ambulances replaced; instead they are being retained on the basis of one per station and will be fully equipped for Major Accident purposes. Past experience of the more serious type of road accidents indicates the need for a vehicle capable of taking all the equipment required at the scene in the very early stages.

Hospital Car Service

During the year the voluntary members of the Hospital Car Service carried 34,475 patients and covered 548,964 miles. These figures represent a vast amount of work which has been carried out selflessly and uncomplaining in all kinds of weather. What they do not show is the social nature of the work as many drivers perform small kindnesses for their patients, both in hospital and at home which, strictly speaking, could be regarded as being outside their normal duties.

In commenting on this side of the work, Mrs. D. R. Lindsay, a driver in West Cumberland, says:

“Some of these patients who are, or have been, very sick tell you their troubles so in most cases you feel you are doing a worthwhile job.”

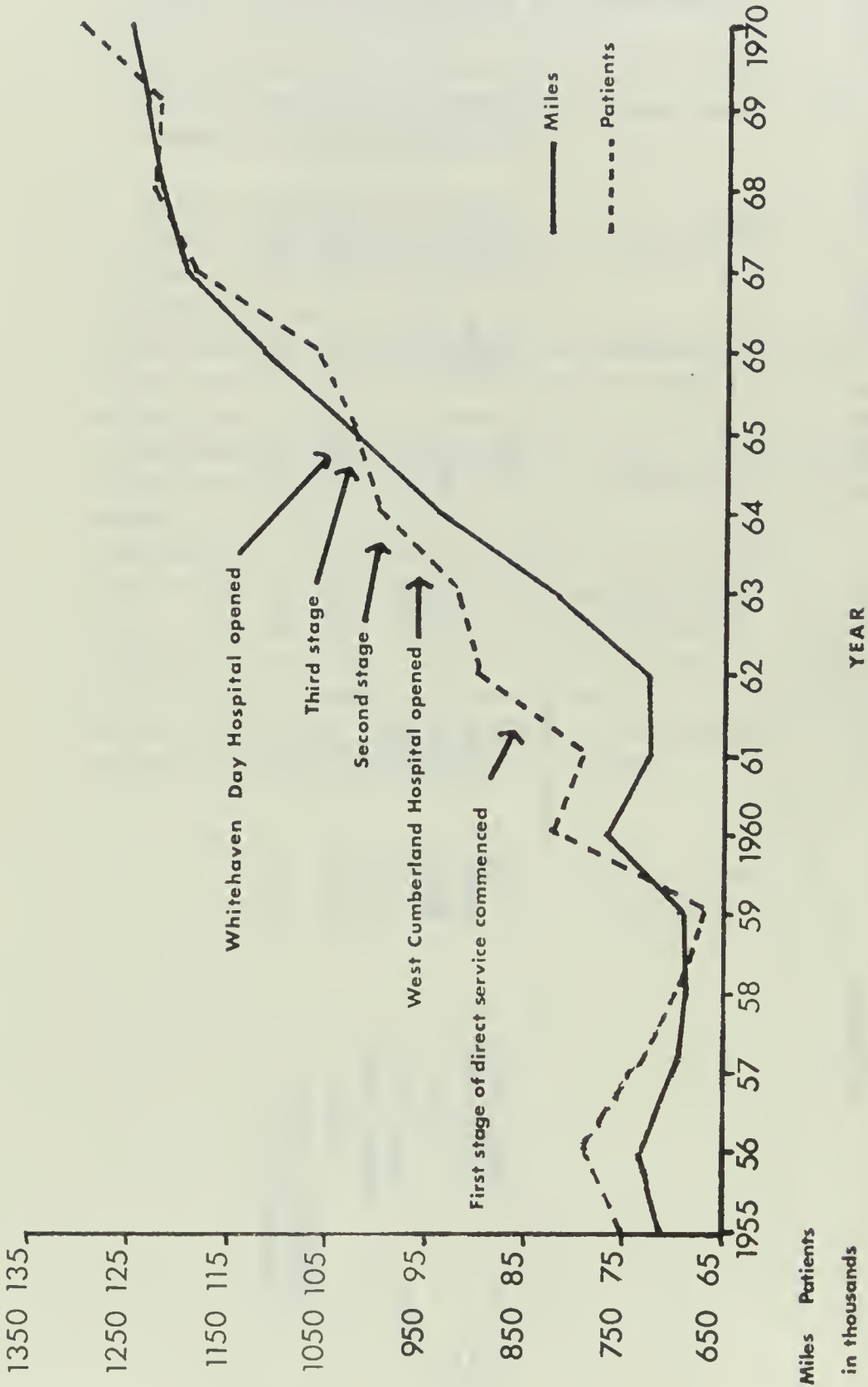
and Mr. H. Jackson, a driver in Carlisle, expresses, I am sure, the attitude of all drivers when he says:

“From time to time, and at various centres, I come into contact with other Hospital Car drivers and from conversations with them I am sure they are just as happy as myself to render any, and every, service possible in this worthwhile work. I take it as an honour and privilege to assist you in serving the community to the best of my ability.”

It will be seen that the Ambulance Service is in excellent shape despite its difficulties and the staff are in good heart as we advance towards a re-organisation of the health service in which it seems inevitable that the Ambulance Service will also share the closest possible alignment with the hospital and community health service in the future. In advance of administrative changes in the health service a reappraisal will be necessary in the year ahead of the role of the Ambulance Service for transport of elderly and handicapped people whose social care now passes to the Department of Social Services. I will be considering this matter in some detail with the Director of Social Services in the course of the coming year. Then again changes in communications systems appear to be on the horizon also with more flexible radio frequencies in use which will allow a great deal more inter-authority ambulance co-operation. All of this complex of development leaves the Ambulance Service with a bright and challenging future and ranks it as one of the key activities supplementary to medicine.

<i>Ambulances</i>		<i>Sitting-Case Cars</i>		<i>Hospital Car Service</i>		<i>Summary of all Services</i>	
		<i>Total No. of Patients carried</i>	<i>Total mileage</i>	<i>Total No. of Patients carried</i>	<i>Total mileage</i>	<i>Total No. of Patients carried</i>	<i>Total mileage</i>
1969	Agency Service ...	495	14727	3357	25506	1091	30090
	Direct Service ...	80047	610240	—	—	36689	549258
	TOTAL ...	80542	624967	3357	25506	37780	579348
1970	Agency Service ...	498	13898	5198	29321	1048	31384
	Direct Service ...	86988	656015	—	—	35427	517580
	TOTAL ...	87486	669913	5198	29321	36475	548964
Increased or decrease compared with 1969		+6944	+44946	+1841	+3815	—1305	—30384
						+7480	+18377

CUMBERLAND GROWTH IN THE USE OF THE AMBULANCE SERVICE



GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

INFECTIOUS DISEASES

The table on notifications of infectious diseases for 1970 is shown on page 157. The outstanding feature of this table, compared with recent years, is the unhappy resurgence of measles at a stage when I would have hoped that this disease was fast disappearing. There can be little doubt that the reason for this resurgence is largely associated with the set-back in the measles vaccination programme which occurred in the latter part of 1969 and early 1970 when certain vaccine was withdrawn and, to some extent, public confidence in the programme set back. However, it is important to appreciate that early this year a thoroughly accredited vaccine again became available and strenuous efforts have been made to ensure as full a take-up of the protection as possible. There are indications that for the young child becoming due for initial measles protection a satisfying figure is being achieved through the computer call up of mothers to family doctor surgeries.

Once again infective jaundice figures too predominantly for comfort in the list of notified diseases. The Millom and Wigton areas of the county have been particularly predominant during 1970 and it is important to repeatedly stress the need for scrupulous personal hygiene, particularly hand hygiene, in preventing the spread of this condition, even although many of the complexities of its epidemiology are not clear.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES 1970

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentery	Acute Encephalitis	Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Food Poisoning	Tuberculosis Respiratory	Meninges and C.N.S.	Other T.B.	Puerperal Pyrexia	Infective Jaundice	Erysipelas	Puerperal Sepsis
Urban Districts:																	
Workington	9	1	—	112	—	—	1	—	—	—	10	—	1	—	3	—	—
Whitehaven	2	1	—	500	—	—	—	—	—	2	4	—	—	—	—	—	—
Cockermouth	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—
Keswick	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1	—	—
Maryport	6	1	—	240	—	—	—	—	—	—	4	—	1	—	6	—	—
Penrith	6	2	—	182	1	—	—	—	—	1	—	—	—	—	9	—	—
Rural Districts:																	
Alston	—	—	—	3	—	—	—	—	—	—	1	—	—	—	—	—	—
Border	1	—	—	58	—	—	—	—	—	—	4	—	2	—	6	—	—
Cockermouth	10	—	—	117	—	—	—	—	—	—	2	—	2	—	5	—	—
Ennerdale	—	—	—	311	2	—	—	—	—	—	7	—	—	—	2	—	—
Millom	1	—	—	203	6	—	—	—	—	1	3	—	—	—	55	—	—
Penrith	9	—	—	46	—	—	—	—	—	—	1	—	1	—	3	—	—
Wigton	14	9	—	215	—	—	—	—	—	—	4	—	—	—	50	1	1
TOTAL	58	14	—	1987	9	—	1	—	—	4	42	—	8	—	140	1	1
FOR YEAR	84	1	—	401	39	—	2	1	—	17	41	—	12	—	82	—	—
1969	...	...	...	742	303	—	—	2	—	2	39	1	10	2	46	—	—
1968	...	51	—	2204	37	—	—	—	—	2	46	—	11	11	—	—	—
1967	...	76	—	1181	14	—	—	1	—	4	54	—	13	33	—	—	—
1966	...	83	—	3480	261	—	—	—	—	10	56	2	10	7	—	—	—
1965	...	17	—	1064	12	—	—	—	31	4	73	2	13	2	—	—	—
1964	...	152	—	...	...	—	—	—	1	—	—	—	—	—	—	—	—

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights & Measures for the following report:—

FOOD AND DRUGS ACT, 1955

Summary of work done under the above Act during the year ended 31st December, 1970.

	Total Samples	Genuine	Unsatisfactory
Milk	530	408	122
Other Food	292	277	15
	<hr/>	<hr/>	<hr/>
	822	685	137
	<hr/>	<hr/>	<hr/>

During the year 822 samples were obtained, 530 being milk and 292 various foods and drugs. Of these, 6 milk and 280 others were analysed by the Public Analyst the remainder being tested by the Sampling Officers.

The samples of milk submitted to the Analyst were tested for the presence of antibiotics in addition to the ordinary compositional analysis; no antibiotics were detected.

The average quality of the milk tested by the Sampling Officers, including those below standard, was 3.66% fat and 8.62% solids-not-fat compared to a presumptive standard of 3.0% and 8.5% respectively.

The percentage of unsatisfactory samples, of the total number obtained, was 16.6% or, in separate categories, 23% of the milk samples and 5.1% of other foods were unsatisfactory.

In addition to milk samples the Sampling Officers also tested 12 informal samples of sausage rolls and meat pies to ascertain if the proportions of meat were in accordance with the required standards.

Unsatisfactory samples were dealt with as follows:—

Milk

Of the 6 samples submitted to the Analyst one proved to be sub-standard but genuine; a second sample from the same source was satisfactory. The remaining 121 samples, tested by the Sampling Officers, consisted of 12 deficient in fat, 83 deficient in solids-not-fat and 26 which contained extraneous water the presence of which was indicated by freezing point tests.

The majority of the samples deficient in fat were taken in the spring when the deficiencies could possibly be attributed to normal seasonal variations but later samples from the same sources of supply were satisfactory. The slight deficiencies of solids-not-fat in 83 of the samples did not appear to be due to any added water but to natural causes. In most instances further samples were taken which proved to be satisfactory. With regard to the samples which contained added water investigations revealed that some producers, having changed to the bulk tank system where milk is piped into a refrigerated tank instead of into separate churns, were not taking sufficient care in cleansing the milking plants and some water was inadvertently getting into the milk. They were advised of the possible consequence if they did not take steps to prevent recurrences.

Food items other than Milk

The table indicates 15 unsatisfactory items, details of which are as follows:—

Three samples of pork sausage, though satisfactory in meat content, contained the preservative sulphur dioxide. The attention of the retailers was drawn to a requirement in the 'Preservatives in Food Regulations' that when such a preservative is added to sausage its presence must be declared by a notice conspicuously displayed and easily readable by a customer; vice versa another sample of sausage did not contain any preservative but a notice in the shop declared that it did. Enquiries indicated there were two types of sausage on sale, one being a factory made sausage which contained preservative whilst the other was made on the premises without the

addition of preservative. Arrangements were made for a combined notice to be displayed to prevent any misunderstanding by customers.

The attention of the manufacturers concerned was drawn to the following items; grapefruit marmalade deficient in soluble solids, pork sausage deficient in meat, calorie reduced mashed potatoes incorrectly labelled and two instances of shandy deficient in alcohol content.

A soft drink (lemon squash), labelled as containing sugar and permitted artificial sweetener, was found to contain cyclamic acid which is banned as an artificial sweetener. The firm concerned was prosecuted and fined £5 plus £1/7/- costs.

No action was taken when a sample of glucose drink was found to contain less benzoic acid than the amount stated on the label because this was not detrimental to the food value of the drink.

The remaining four unsatisfactory articles of food were sent to the Analyst following complaints received from the purchasers. One was a bottle of 'lemonade' which consisted mainly of water with a minute trace of lemonade. Apart from drawing the attention of the manufacturer to the matter, no other action was contemplated as the bottle had been opened and kept in the house of the purchaser for more than a week. There were children in the family concerned which might be the reason for the bottle being nearly full yet having contents tasting remarkably like water. A formal sample of lemonade, from the same source of supply and submitted for analysis at the same time as the suspect portion, was found to be genuine. In the case of a bottle of appleade the Analyst's findings confirmed a complaint that the drink contained extraneous matter and the manufacturer was cautioned. A bag of self raising flour was found to contain a piece of cigarette paper and numerous small fragments of tobacco leaf for which the manufacturers were prosecuted and fined £50 plus £5 costs. A firm of food manufacturers was cautioned for selling corned beef which contained a tuft of hair.

In addition to the above complaints several were received which did not necessitate the articles of food being sent to the Analyst. One concerned some mincemeat which contained a piece of glass for which the manufacturer was fined £50 plus £2 costs. Legal proceedings were also instituted against the manufacturers of a choc-ice bar which contained a piece of metal and they were fined £25. Another prosecution concerned corned beef in which was embedded a piece of metal similar to a chain link and the firm concerned was fined £10. One investigation concerned a large wooden splinter alleged to have been in a meat pie. It appeared that the splinter could have come from one of the large wooden bread trays on which the pies had been placed before being capped. Legal action was not contemplated as the complainant had destroyed the pie and the splinter was really too big to have been swallowed or to have caused damage to the mouth but the matter was brought to the notice of the baker.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1970

(N.B.—Corresponding figures for 1969 are shown in brackets)

		Alston R.D.C.	Border R.D.C.	Cocker- mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	White- haven Boro'	Work- ton Boro'	Cocker- mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.	Total for County
	Population — 1951 (Census) — 1961	2,327 2,105	29,845 29,644	20,455 20,966	29,676 30,859	13,428 13,094	11,723 11,638	23,746 21,866	24,620 27,566	28,891 29,552	5,235 5,827	4,868 4,765	12,234 12,393	10,492 10,927	217,540 223,202
A	1 Total number of occupied dwelling houses in the district ...	901 (889)	9,627 (9,513)	7,241 (7,235)	10,326 (10,312)	4,546 (4,582)	3,759 (3,763)	7,764 (7,700)	8,349 (8,246)	9,573 (9,595)	2,173 (2,141)	1,712 (1,668)	4,201 (4,189)	3,725 (3,680)	73,897 (73,513)
	2 Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings: ...	— (—)	— (—)	17 (53)	94 (107)	28 (46)	20 (27)	11 (12)	8 (14)	7 (2)	11 (12)	4 (4)	42 (42)	13 (10)	255 (329)
	3 Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost: ...	11 (13)	196 (238)	23 (49)	55 (60)	317 (316)	459 (450)	343 (303)	20 (20)	950 (1,100)	34 (117)	4 (4)	32 (55)	59 (62)	2,503 (2,787)
	4 Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit: ...	— (36)	430 (450)	N.A. (N.A.)	N.K. (N.K.)	213 (216)	380 (400)	976 (946)	— (10)	2,400 (2,500)	85 (72)	1 (15)	40 (48)	25 (56)	4,550 (4,749)
	5 Number of houses found to be overcrowded: ...	6 (4)	10 (8)	3 (4)	— (—)	4 (5)	3 (3)	3 (3)	— (—)	9 (—)	— (—)	N.K. (N.K.)	— (—)	3 (4)	41 (31)
B	WAITING LISTS														
	Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above: ...	48 (60)	127 (113)	460 (558)	280 (199)	171 (170)	92 (88)	604 (537)	714 (649)	875 (889)	200 (205)	125 (87)	441 (330)	275 (298)	4,412 (4,183)
C	NEW DWELLINGS COMPLETED DURING THE YEAR														
	1 By or for the Council—														
	For aged persons ...	— (—)	35 (10)	15 (6)	— (—)	— (7)	— (—)	7 (24)	— (—)	86 (—)	— (—)	1 (—)	8 (—)	— (—)	150 (47)
	For aged persons grouped with welfare facilities ...	— (—)	— (—)	— (—)	— (—)	— (10)	— (—)	— (—)	— (—)	20 (—)	— (—)	— (—)	— (—)	— (—)	20 (10)
	For agricultural dwellings ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings ...	12 (23)	56 (76)	29 (22)	— (2)	1 (20)	— (—)	— (4)	14 (8)	62 (—)	— (—)	24 (31)	8 (—)	8 (42)	214 (228)
	2 Private building ...	3 (3)	67 (91)	42 (35)	51 (54)	21 (15)	16 (23)	53 (51)	50 (46)	48 (27)	37 (42)	8 (5)	13 (14)	77 (52)	486 (458)
	Total of 1 and 2 ...	15 (26)	156 (177)	86 (63)	51 (56)	22 (52)	16 (23)	60 (79)	64 (54)	216 (27)	37 (42)	33 (36)	29 (14)	85 (94)	870 (743)
D	1 Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants) ...	12 (14)	96 (44)	131 (70)	93 (71)	45 (32)	61 (61)	90 (120)	96 (38)	85 (60)	24 (10)	10 (10)	56 (96)	29 (28)	828 (654)
	2 Number of houses for which grants were approved: ...	11 (14)	95 (39)	131 (70)	90 (66)	48 (31)	59 (53)	145 (104)	96 (38)	91 (49)	24 (10)	9 (10)	56 (96)	26 (28)	881 (608)
	3 Number of houses where improvements were carried out and grants paid: ...	7 (10)	48 (37)	61 (66)	70 (59)	39 (31)	50 (61)	108 (39)	44 (62)	47 (47)	10 (7)	14 (7)	42 (37)	18 (13)	558 (476)
	4 Number of houses purchased or taken over by the Council with a view to improvement or conversion: ...	— (—)	— (4)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (149)	— (—)	— (—)	1 (—)	— (1)	1 (154)
	5 Number of houses improved by the Council—														
	(i) with grant ...	— (—)	— (—)	— (14)	3 (2)	— (—)	— (—)	4 (20)* (1)	7 (—)	— (9)	— (—)	1 (—)	— (—)	14 (16)	49 (42)
	(ii) without grant ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	20 (72)* (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
E	HOUSING PROGRAMME FOR ENSUING YEAR—														
	1 Dwellings to be built by or for the Council—														
	For aged persons ...	— (—)	2 (33)	— (12)	9 (—)	8 (8)	16 (28)	48 (21)	21 (16)	30 (20)	— (—)	— (—)	89 (4)	— (—)	223 (142)
	For aged persons grouped with welfare facilities ...	— (6)	— (—)	— (—)	24 (22)	— (—)	14 (14)	20 (—)	— (—)	40 (1)	— (—)	— (—)	20 (—)	20 (20)	138 (63)
	For agricultural workers ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings ...	12 (6)	53 (45)	— (23)	16 (22)	4 (5)	2 (6)	48 (9)	40 (20)	52 (184)	25 (10)	26 (50)	153 (300)	28 (36)	459 (716)
	2 Private building ...	3 (4)	110 (90)	50 (40)	45 (50)	18 (23)	20 (25)	40 (60)	60 (40)	100 (50)	43 (45)	30 (14)	20 (40)	70 (100)	609 (581)
	Total of 1 and 2 ...	15 (16)	165 (168)	50 (75)	94 (94)	30 (36)	52 (73)	156 (90)	121 (76)	222 (255)	68 (55)	56 (64)	282 (344)	118 (156)	1,429 (1,502)

* The figures in brackets relate to houses improved between 1966 and 1969 previously omitted.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from the study.

4. The fourth part of the report is a summary of the work. It briefly reviews the main points of the report and states the conclusions.

5. The fifth part of the report is a list of references. It includes the names of the authors and the titles of the papers or books referred to in the report.

6. The sixth part of the report is a list of symbols and abbreviations. It defines the symbols and abbreviations used in the report.

7. The seventh part of the report is a list of figures. It includes the titles of the figures and the pages on which they are located.

8. The eighth part of the report is a list of tables. It includes the titles of the tables and the pages on which they are located.

9. The ninth part of the report is a list of appendices. It includes the titles of the appendices and the pages on which they are located.

10. The tenth part of the report is a list of footnotes. It includes the footnotes referred to in the report.

11. The eleventh part of the report is a list of errata. It includes the corrections to the report.

12. The twelfth part of the report is a list of acknowledgments. It includes the names of the people who helped in the work.

13. The thirteenth part of the report is a list of conclusions. It states the conclusions drawn from the study.

14. The fourteenth part of the report is a list of recommendations. It includes the recommendations made by the study.

15. The fifteenth part of the report is a list of references. It includes the names of the authors and the titles of the papers or books referred to in the report.

16. The sixteenth part of the report is a list of symbols and abbreviations. It defines the symbols and abbreviations used in the report.

APPENDICES

- I. Annual Report on Tuberculosis and Other Chest Diseases in
West Cumberland.**
- II. Annual Report on Tuberculosis and Other Chest Diseases in
East Cumberland.**
- III. County Council Clinics.**

APPENDIX I.

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland by Dr. R. Hambridge

During 1970 there has been a slight further improvement in the situation arrived at last year so far as tuberculosis in West Cumberland is concerned. The Tuberculosis Register at the 31st December, 1970 was made up of the following numbers of cases:—

	<i>Men</i>	<i>Women</i>	<i>Children</i>	<i>Total</i>	
Respiratory T.B.	350	212	14	576	(728)
Non-Respiratory T.B.	31	41	8	80	(67)
Total	381	253	22	656	(795)

(Figures in brackets relate to comparable data for 1969)

Some 65 cases were removed from the Register deemed recovered during the year: and a further 8 cases died of various causes — 3 of these from tuberculosis. The Register was augmented by 68 new cases diagnosed during the year; details of these are tabulated as follows:—

<i>New Cases:</i>	<i>Men</i>	<i>Women</i>	<i>Children</i>	<i>Total</i>
Requiring observation only	20	17	2	39
Requiring treatment:—				
Respiratory	11	14	—	25
Non Respiratory Forms	—	4	—	4
Total	31	35	2	68

Of the respiratory cases requiring treatment drawn from both old and new case categories 22 were infectious at diagnosis. Although the number of new cases is appreciably less than a few years ago the proportion of them diagnosed before they have reached a frankly infectious form has fallen from around 75% to 50%, confirming the tendency noted in this report last year.

Of the three patients who died during the year of tuberculosis two were not known to be sufferers from the disease until diagnosis at autopsy.

EXAMINATION OF CONTACTS:

The tracing of familiar and household contacts of new cases has continued: in the main only children and infants have been seen at Outpatients, adults being referred to the Static 100 m.m. X-ray Units at Workington Infirmary and the West Cumberland Hospital. All children between the ages of 3 months and 15 years, not already vaccinated with B.C.G. at school, have been tuberculin-tested (1/1000 O.T.) and non-reactors vaccinated. Below the age of 3 months, tuberculin-testing has been dispensed with and B.C.G. vaccination given ab initio.

A total of 263 contacts — children over 15 and adults — are known to have passed through the Static M.M.R. Units, no cases of notifiable disease being found.

B.C.G. VACCINATION:

A total of 244 infants and children, including new-borns, was vaccinated with B.C.G. (331 in 1969).

STATIC MASS X-RAY (100 mm.) UNITS:

Two units have operated, each on a part-time basis, during the year. The reduction in the total amount of work done and the diagnostic usefulness of the units is again evident in the annual figures, details of which follow:—

STATIC MMR UNITS — 1970
WEST CUMBERLAND HOSPITAL

	No. of Miniature films taken	Number recalled for clinical examination	Active T.B.	Inactive T.B.	Neoplasms	Sarcoid	Acquired Cardiac Conditions	Pneumoconiosis without PMF
General Public	1,278	13	2	1	—	—	1	—
Doctors' Cases	751	30	—	6	4	1	—	2
Contact Cases	89	—	—	—	—	—	—	—
Outpatients	550	4	1	2	—	—	—	—
Firms	659	1	—	—	—	—	—	—
Scholars	58	—	—	—	—	—	—	—
TOTALS	3,385	48	3	9	4	1	1	2

WORKINGTON INFIRMARY

General Public	760	3	—	—	—	—	—	—
Doctors' Cases	823	28	1	4	5	—	—	3
Contact Cases	174	1	—	—	—	—	—	—
Outpatients	6	—	—	—	—	—	—	—
Firms	528	2	—	—	—	—	1	—
Scholars	29	—	—	—	—	—	—	—
TOTALS	2,320	34	1	4	5	—	1	3
TOTAL BOTH UNITS	5,705	82	4	13	9	1	2	5
do. 1969	6,736	122	8	7	20	4	3	7
do. 1968	6,683	111	5	10	11	2	4	5

The proportion of general practitioner referrals has fallen from 35% of this total number of persons examined in 1969 to 27%.

OUTPATIENT CLINICS:

Sessions have continued at both Workington Infirmary and the West Cumberland Hospital at which 271 and 217 new patients were seen respectively. At each centre 577 and 556 old patients attended, giving a total of outpatient attendances for 1970 of 1621.

INPATIENTS:

During the year there were 65 tuberculous admissions to Home-wood (40 men and 25 women); and 107 admissions of a variety of non-tuberculous conditions (76 men, 31 women), giving a total of 172 admissions. 14 patients were transferred to Seaham Hall for thoracic surgery.

PULMONARY NEOPLASM:

The number of these cases diagnosed by Mass X-Ray (9) was roughly half that of 1969 (20). In all, 38 cases were dealt with during the year (48 in 1969), 33 men and 5 women. The survival rate remains depressingly low, 20 of the 38 not surviving the year. Resection proved possible in 6 patients (10 in 1969). There were 10 further deaths from this cause in patients diagnosed prior to 1970.

An increasing number of sufferers from a variety of conditions giving rise to pulmonary heart disease and respiratory insufficiency are attending Chest Outpatients and being admitted to the Chest Wards. These again outnumbered the annual combined incidence of pneumoconiosis and tuberculosis in West Cumberland.

APPENDIX II.

Annual Report on Tuberculosis and other Chest Diseases in East Cumberland in 1970 by Dr. R. J. C. Southern

Introduction

The work-load on the chest centre has been heavy throughout 1970. Despite efforts to keep re-attendances down to the minimum, many routine re-appointments have been delayed by the pressure of new cases.

This is the first full year with only two medical staff working at the chest centre, and the total attendances have fallen slightly.

A total of 8316 attendances was recorded in 1970 compared to 9637 in 1969. The number of new patients increased by 156 to a total of 1593.

Tuberculosis

Table 1 shows the number of cases on the Tuberculosis Register at 31.12.70.

TABLE 1.

	East Cumberland	Carlisle City	North Westmorland	Total
Respiratory	126	138	14	278
Non-Respiratory	11	27	2	40
	137	165	16	318

During the year 42 cases were removed from the Register, 21 through death; of these, three died with active disease and two of the deaths were directly attributable to tuberculosis.

Table 2 shows the number of new cases diagnosed during the year, the figures for 1969 being in brackets.

TABLE 2.

	Respiratory				Non-Respiratory			
	M	W	Ch	Total	M	W	Ch	Total
East Cumberland ...	8	5	1	14 (9)	—	2	—	2 (2)
Carlisle City ...	18	7	1	26 (9)	—	6	—	6 (3)
North Westmorland	—	1	—	1 (1)	—	—	—	— (—)
	26	13	2	41 (19)	—	8	—	8 (5)

Table 3 shows the number of beds available for respiratory disease; these are unchanged. There is no shortage of beds, the problem is the general shortage of nurses.

TABLE 3.

Hospital	Beds available	No. discharged in 1970	No. discharged in 1969
Longtown Hospital	26	108	115
Ward 18, Cumberland Infirmery	13	218	247

The increase of 25 cases of respiratory tuberculosis, which includes four cases of pleural effusion, is disturbing, although the increase in East Cumberland is less than that in the City of Carlisle. When dealing with relatively small numbers an increase of this order may not be as significant as it at first appears, but for many years there has been a gradual fall in the number of new cases, both nationally and locally. Complete figures for England and Wales are not yet available but provisional figures for 1970 suggest that nationally this fall has continued. The increase is not confined to any particular age group, and more than 50% of these cases were infectious at the time of diagnosis.

Of the new cases, three were contacts of previously known cases; four had known lesions, previously thought to be inactive, and two had previously been on the Tuberculosis Register but had been considered cured in 1962 and 1964 respectively. Neither of these had had what would now be considered an adequate course of chemotherapy.

Only one new case was an immigrant.

Of the younger patients, two had been previously vaccinated with B.C.G. at school and must be considered vaccination failures; three had refused Mantoux testing or B.C.G. vaccination, and two had already shown positive Mantoux tests at school. Of the 26 new cases in Carlisle, ten were discovered by mass radiography. Of the 14 new cases in East Cumberland only three were discovered by this means. These figures reflect the availability of the Mass Miniature Radiography service and it could well be that more cases would be diagnosed in East Cumberland if a mass radiography service were available.

Examination of contacts

A total of 1462 new contacts were seen in 1970 compared to 1296 in the previous year; four cases of active tuberculosis were discovered as a result.

In addition 17 infants and children were found to have positive Mantoux tests and these have been given prophylactic chemotherapy which much reduces the risk both of acute manifestations such as tuberculous meningitis now and pulmonary disease in the future.

As usual, a number of contacts declined to attend for examination.

All Mantoux negative contacts were offered B.C.G. vaccination and those vaccinated five or more years ago whose Mantoux reactions had reverted to negative were re-vaccinated. Whether re-vaccination is necessary is not known with certainty. British and Scandinavian figures suggest that it is not, yet two of our new cases had been vaccinated some years previously. Whether they were ever Mantoux negative in the interval is not known.

Table 4 shows the number of B.C.G. vaccinations carried out during the year.

TABLE 4.

No. of B.C.G. vaccinations carried out

				1970	1969
East Cumberland	...	...	...	123	85
Carlisle City	...	...	...	187	60
North Westmorland	...	...	...	21	11
Hospital staff	...	...	...	53	61
				384	217

The x-ray examinations of Mantoux positive school children revealed no cases of tuberculous disease.

There is a possibly significant difference in the spontaneous Mantoux conversion rates in children of 12/13 in East Cumberland and Carlisle although opinions may differ on the interpretation of Mantoux tests. In 1970 the incidence in the Northern region of the County area was 2.27% and in the same year the incidence in Carlisle City was 0.86%. Whether this difference is due to a high incidence of infection with the almost non-pathogenic avian tubercle bacillus in the Country areas, or whether there is a pool of undiscovered human cases of tuberculosis in the County area is not yet known.

Approximately 10% of school children do not get Mantoux tested because parental consent has not been given and consequently about 10% of the young adult population have not been protected by B.C.G.

It is obvious that the problem of tuberculosis is still with us and if the disease is to be kept to the minimum this is no time to reduce either effort or resources in combating it. Doctors must be actively on the look out for the disease; x-rays must be readily available to the general public; contacts must be not only sought out but be persuaded to come for examination; all lesions of doubtful activity and children with recent Mantoux conversion must, so far as possible, be treated rather than observed, and the parents of the 10% of school children who withhold permission for

tuberculin testing must be reasoned with, so that the ideal of 100% protection of school leavers by B.C.G. may be attainable.

Bronchial Carcinoma

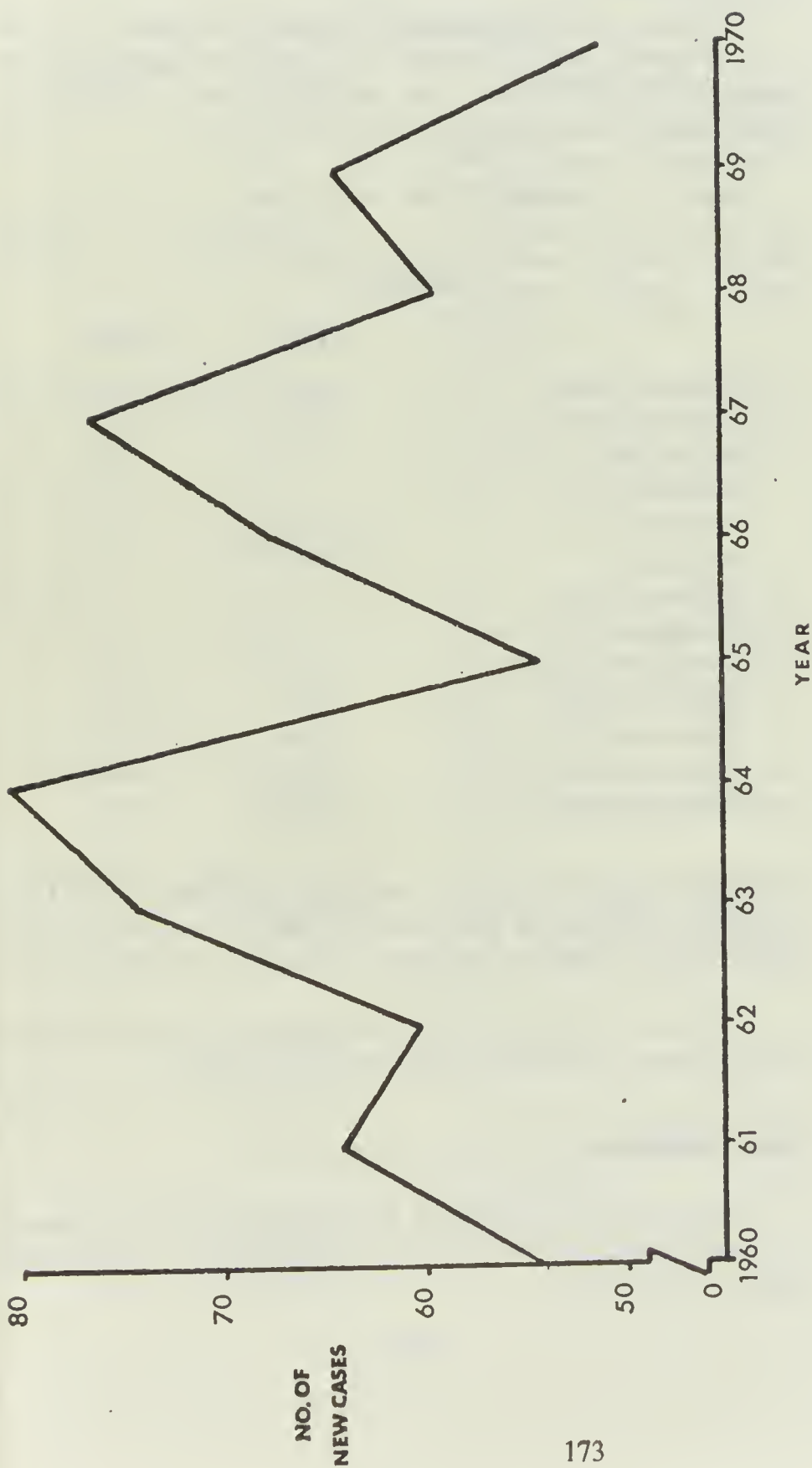
Figure 1 shows the number of new cases of bronchial carcinoma seen **at the Chest Centre** during the last ten years. In addition an unknown number of cases have been seen at the Cumberland Infirmary and the City General Hospital in 1970. Only 6 cases seen at the chest centre were submitted for surgery.

Of the 51 cases (46 male and 5 female) seen at the chest centre in 1970, 26 were discovered through mass radiography; 24 of the new cases had already died before the end of the year.

After the second report of the Royal College of Physicians and its attendant publicity, there is little more to be said on this topic. Cigarette smoking remains the chief cause. The medical profession have failed over the years to make any significant impression, either by advice or example, on this problem. Perhaps the Government and the professional persuaders could do more if they would.

Contrary to the increasingly depressing national figures, there has been no increase in the number of new cases of bronchial carcinoma seen at the chest centre over the past few years.

BRONCHIAL CARONONA —
NEW CASES PER YEAR 1960 - 1970
FIGURE 1



Mass Radiography

The Static unit has continued to operate throughout the year at 1 Brunswick Street, Carlisle, and there has again been an increase in the work done. The mobile unit from Newcastle has also conducted three surveys in the area.

Table 5 is a summary of the work done.

TABLE 5.

	1970	1969
Miniature films	6674	6419
Referred for clinical	434	324
Active T.B.	17	4
Inactive T.B.	8	14
Bronchiectasis	3	5
Neoplasm	26	17
Pneumoconiosis	2	1
Sarcoidosis	1	2
Cardiac conditions	30	29
Doctors cases	3014	3152
Contacts per chest centre	234	37
General public	2307	2416
Works personnel	1119	814

These figures confirm the continued usefulness of the Unit, not only for diagnostic purposes but also for screening groups such as contacts and new members of hospital and school staffs.

One hopes that the Unit will continue to be as well patronised when it moves to the City General Hospital in 1971.

Acknowledgements

My thanks are due to Dr. H. L. R. Sargent and to the nursing and clerical staffs for their continued hard work and co-operation during the past year.

APPENDIX III

County Council Clinics

Centre		Address		Clinic Services
Alston	...	Cottage Hospital, Alston		Child Health, Chiropody, Dental, Family Planning, Vaccination and Immunisation.
Aspatria	...	St. Mungo's ... Park, Aspatria		Child Health, Dental, Chiropody, Social Classes for Blind and other handicapped, Speech Therapy, Mothercraft, Vaccination and Im- munisation.
Brampton	...	Union Lane, ... Brampton		Cervical Cytology, Child Health, Child Care (Children's Department), Mothercraft, Chiropody, Dental and Vaccination and Immunisation.
Broughton	...	Nurse's House, ... Little Broughton		Child Health.
Carlisle	...	14, Portland ... Square, Carlisle CA1 1PY		Artificial Limb and Appliances, Cervical Cytology, Child Guidance, Chiropody, Dental, Hearing, Oph- thalmic, Orthoptic, Orthopaedic and Speech Therapy.
Cleator Moor	...	Ennerdale Rd., ... Cleator Moor		Ante-Natal, Cervical Cytology, Chiropody, Dental, Vaccination and Immunisation.
Cockermouth	...	Harford House, ... Main Street, Cockermouth		Cervical Cytology, Child Health, Chiropody, Dental, Ophthalmic, Speech Therapy, Developmental Testing, Vaccination and Immunisa- tion.
Dalston	...	Victory Hall, ... Dalston		Child Health.
Egremont	...	St. Bridget's ... Lane, Egremont		Ante-Natal, Child Health, Chiro- pody, Speech Therapy, Vaccination and Immunisation.
Frizington	...	Council Cham- ... bers, Frizington		Ante-Natal,

Centre		Address		Clinic Services
Houghton	...	The Village Hall	.	Child Health.
		Houghton		
Hunsonby	...	The Village Institute,	...	Child Health.
		Hunsonby		
Keswick	...	13-15 Bank St.,	...	Cervical Cytology, Child Health,
		Keswick		Dental, Ophthalmic, Relaxation,
				Speech Therapy, Developmental
				Testing, Vaccination and Immunisation.
Longtown	...	Burn Street,	...	Cervical Cytology, Child Health,
		Longtown		Dental, Mothercraft, Orthopaedic,
				Play-group, School Clinic, Hearing,
				Weight Reduction, Chiropody, Pro-
				bation, Social Class for Handicapped,
				Ante and Post-Natal, O.P.W.
				meetings, Blood Transfusion, Vac-
				cination and Immunisation.
Maryport	...	24, Selby Terrace,	...	Ante-Natal, Cervical Cytology (at
		Maryport		surgery), Child Guidance, Child
				Health, Dental, Obesity (at surgery),
				Speech Therapy, Developmental
				Testing, Vaccination and Immunisation.
		Cottage Hospital	.	Chiropody.
Millom	...	18, St. George's	...	Ante-Natal, Cervical Cytology, Child
		Road, Millom		Guidance, Child Health, Dental,
				Family Planning, Speech Therapy,
				Vaccination and Immunisation.
Nenthead	...	Overwater,	...	Child Health, Vaccination and Im-
		Nenthead		munisation.
Penrith	...	Brunswick Sq.,	...	Cervical Cytology, Child Care
		Penrith		(Children's Department), Child
				Health, Child Guidance, Playgroup,
				Special Care Unit, Chiropody, Den-
				tal, Family Planning, Hearing,
				Marriage Guidance, Mothercraft,
				Orthopaedic, Orthoptic, Probation,
				Psychiatric, Speech Therapy, Social
				Class for Handicapped, Vaccination
				and Immunisation.

Centre	Address		Clinic Services
Scotby	...	The Village Hall . Scotby	Child Health.
Seascale	...	Gosforth Road, ... Seascale	Child Health, Dental, Chiropody. Vaccination and Immunisation.
Seaton	...	Miners' Welfare ... Hall, Seaton	Child Health.
Silloth	...	O.P. Welfare ... Hut, Silloth	Chiropody.
Thursby	...	The Church Hall . Thursby	Child Health.
Wetheral	...	The Village Hall . Wetheral	Child Health.
Whitehaven	...	Flatt Walks ... Clinic, Whitehaven	Ante-Natal, Cervical Cytology, Child Guidance, Child Health, Chiropody, Dental, Family Planning, Hearing Therapy, School Speech Therapy, Vaccination and Immunisation.
Mirehouse	...	Dent Road, ... Mirehouse, Whitehaven	Ante-Natal, Child Health, Vaccina- tion and Immunisation.
Woodhouse	...	Woodhouse, ... Whitehaven	Child Health, Mothercraft, Vaccina- tion and Immunisation.
Wigton	...	Birdcage Walk. ... Wigton	Cervical Cytology, Child Health, Chiropody, Dental, Probation, Mothercraft, Orthopaedic, Speech Therapy, and Vaccination and Im- munisation.
Workington	...	Park Lane, ... Workington	Cervical Cytology, Child Guidance, Child Health, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, Speech Ther- apy, Developmental Testing, Vacci- nation and Immunisation.
Salterbeck	...	Holden Road, ... Salterbeck. Workington	Cervical Cytology, Child Health, Chiropody, Dental, Developmental Testing, Vaccination and Immunisa- tion.

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